REHABILITATION RECORD

November & December 1972

WHEELCHAIR DECOR

see page 29

Congressional Hearings on Barriers

Commissioner Edward Newman

Commissioner John Martin

The following is an excerpt of a joint statement made at hearings before the Special Committee on Aging in the U.S. Senate. The statement was made by Commissioner Edward Newman, RSA, and Commissioner John B. Martin, AOA. The hearings inquired into various aspects of a barrier-free environment for the elderly and the handicapped.

Concurrent to the efforts toward eliminating architectural barriers to access to buildings and other facilities has come growing awareness of other environmental barriers that block full realization by each disabled person of his or her potential or which limit activity of the aged just as surely as if they were in jail. Chief of these are in transportation facilities and housing.

. . . . . .

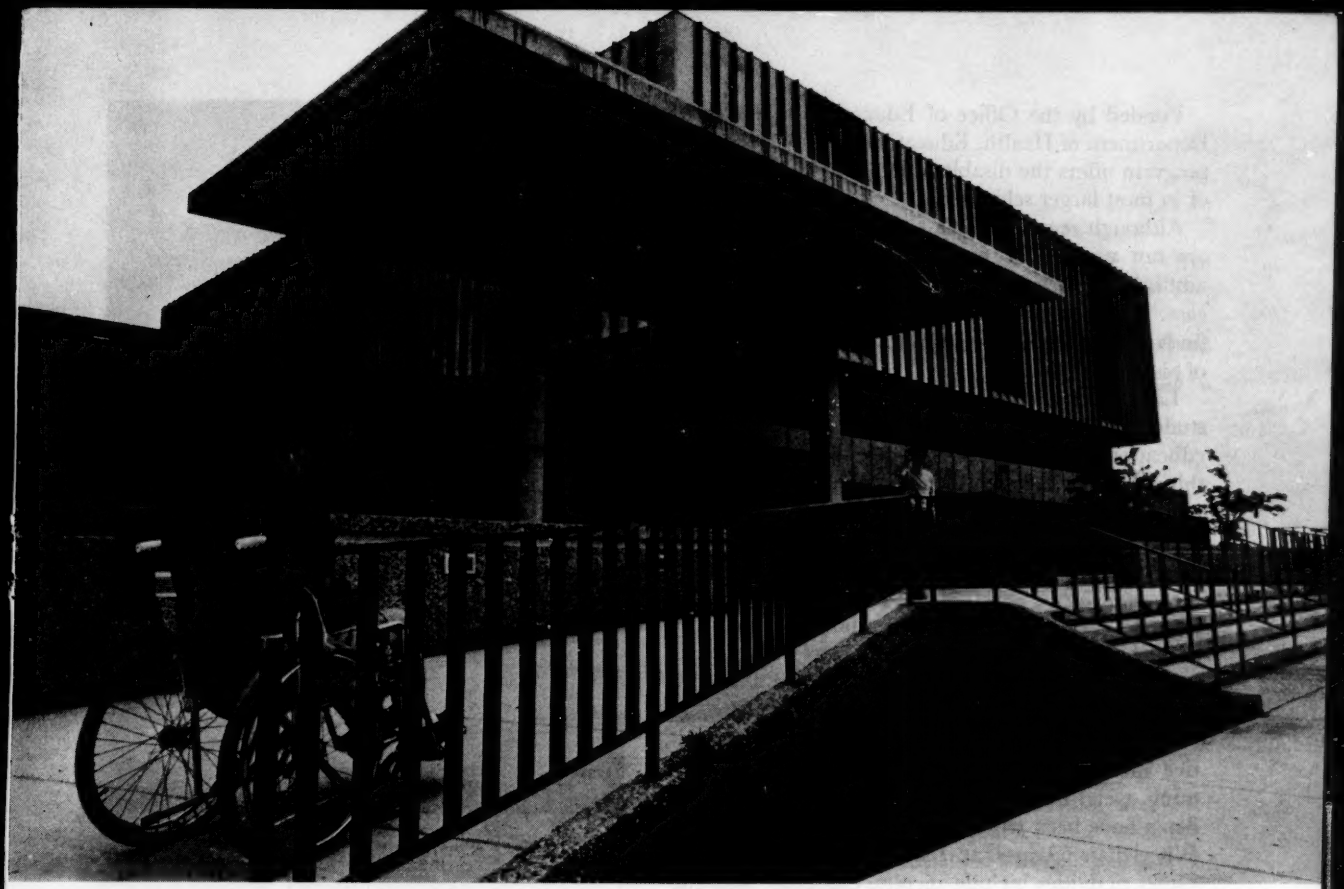
Although the Congress has provided for special housing help for the elderly and disabled in the National Housing Act, the Act remains to be fully implemented by community and organization initiatives. Housing presents particular problems, just now being fully understood. Accessibility and the required features are, of course, a must. But one housing project for the aged and disabled in Seattle, funded in part by the Department of Housing and Urban Development, has made clear an additional requirement: personal services, available to assist the disabled person as required.

Unlike accessibility and transportation, housing-related service needs vary somewhat between the aged and the younger handicapped because of varying interests and views. Housing goes beyond transportation and accessibility to structures in that it shapes a total atmosphere of living.

The best solution to design of building for full use by all citizens is to design accessibility before initiation of construction. Studies of the cost of accessibility show that proper design incorporated from the beginning adds no more than 1 percent to the cost of a building.

Clearly, architects and city planners are the key to accessibility. In recognition of this, the American Institute of Architecture, in cooperation with the Rehabilitation Services Administration, and other Federal agencies (HUD, GSA, and other parts of HEW), conducted two-day workshops in each of 10 cities across the country. In all, 1,113 persons participated, including 670 architects and engineers. All panelists at all sessions emphasized the need for education of the designer, the builder, the financier, and the general public.

Continuing educational activities in regard to the various barriers to a full life for the disabled is being conducted by the Committee on Barrier-Free Design of the President's Committee on Employment of the Handicapped, and the State and local counterparts of the President's Committee. A widely circulated newsletter records progress and remaining needs.



All Southwest Minnesota State College buildings are ramped or have ground-level access.

Promise On the Prairie

SUSAN D. BLISS

Out of the prairie near the small town of Marshall, Minnesota, rises one of the United States' more ambitious new scholastic programs integrating disabled and nondisabled college students. A charter class of 509 students enrolled at the Southwest Minnesota State College in 1967, and by the fall of 1971, the student body had increased to 3,400.

Minnesota's first 4-year, liberal arts and technical college, SMSC has from the beginning sought an atmosphere to accept and encourage the differences among people. President of the college, Howard Bellows, planned it to be accessible long before there were handicapped students or any rehabilitation funds available. Today, there are 205 disabled students, an accessible campus, and an exciting "rehabilitation education program."

Ms. Bliss is Editor, Performance, *President's Committee on Employment of the Handicapped.*

Funded by the Office of Education of the U.S. Department of Health, Education, and Welfare, the program offers the disabled many facilities unheard of in most larger schools.

Although regular scholastic requirements usually are not waived for prospective disabled students, admissions counselors study carefully each individual case. Once on campus, the handicapped student finds many facilities which help him make the most of his college career.

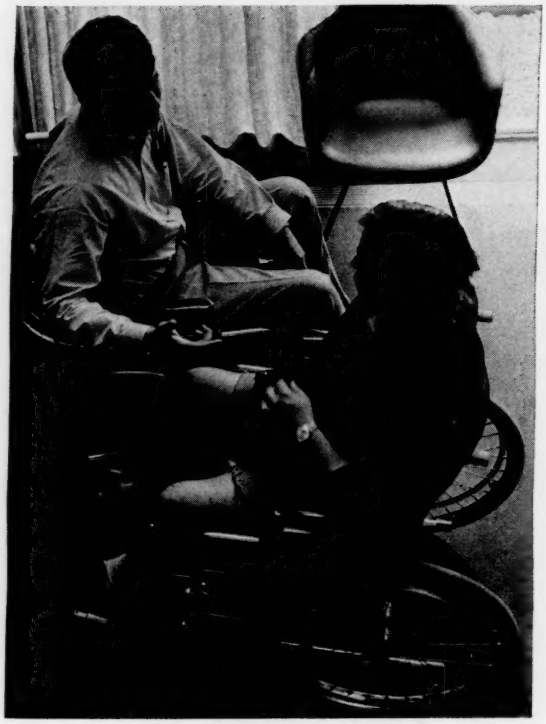
Larry Foukas of Pierre, S.D., for example, repairs students' wheelchairs as part of the rehabilitation education service. It does not cost the students anything to take their wheelchairs or other orthopedic aids for repair. Larry is a paraplegic and double leg amputee, and a freshman at SMSC. Himself a wheelchair sportsman trying to break the national record for handicapped weightlifters, Larry says he gets his biggest "business" from the school's wheelchair basketball team, the Broncos. The team has traveled to Illinois, Missouri, Kansas, and Iowa for games, and it was Minnesota State Champion in 1970.

The school offers disabled students other competitive sports such as track and field, archery, swimming, weightlifting, and target shooting. Some students have been winners in the National Collegiate Wheelchair Games at the University of Illinois. Other activities include picnics, camping, and cultural outings for handicapped students and integrated groups alike.

Among the disabled students on campus are five Vietnam veterans. One is Darwin Madtson, a 24-year-old sophomore from Jasper, Minn. Darwin can be identified easily from across campus by his constant companion, Sarge, a 125-pound Alaskan Malemute who pulls Darwin's wheelchair. The young vet is planning to buy a real dog sled to substitute for his wheelchair in the snow.

As a disabled vet, Madtson has found many barriers in our society. One which can be overcome, he says, is wanting to go back to school after armed forces service. "I wrote to different schools in Southwestern Minnesota," he said. "The replies came back and the only one that was promising was a new college that was all set up for the disabled. I visited the college and found that it was very easy to get around. The program here is very good . . . I know that I will never regret the decision I made."

There was a lot of community spirit behind the building of SMSC. Located 150 miles southwest of Minneapolis-St. Paul in the middle of a huge agricultural area, one of its missions is to be an educational and cultural center for the region. Marshall citizens themselves bought and donated the 200 acres on which the college sits, and they have given their support ever since. Some Marshall residents, long out of high school, are attending SMSC to get degrees.

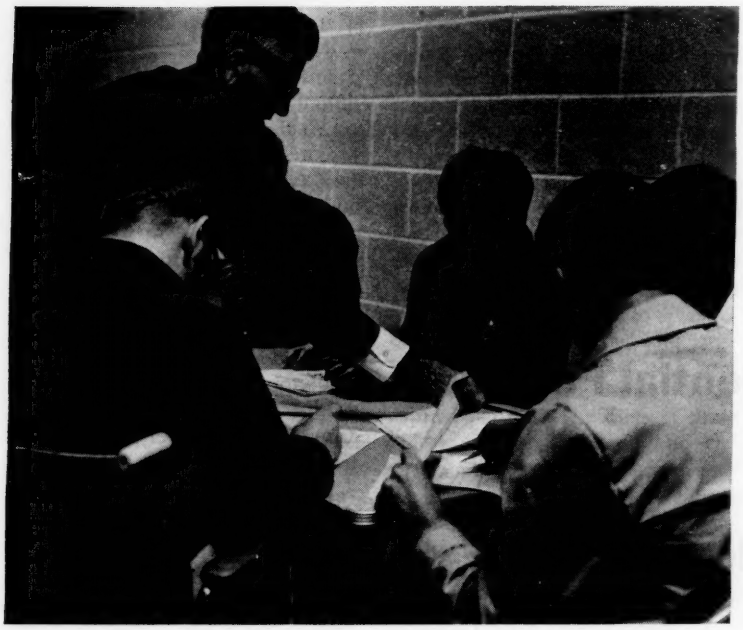


Just "talking" is still a favorite collegiate pastime.

The barrier free design of SMSC residence halls won awards last fall from the Minnesota Society for Crippled Children and Adults.

For the students whose physical limitations prevent them from getting around independently, rehabilitation education services maintain a directory of able-bodied students who volunteer as full-time or part-time assistants at times when help is needed. Although independence is the goal for disabled students at SMSC, the school recognizes that total self-sufficiency is not always possible.

Rehabilitation education services can provide readers, writers, tutors, and mechanical devices for students who require them. Although the blind have found such aids most helpful, those with orthopedic handicaps, who may have difficulty writing, have also used the services.



Philosophy at State is that disability becomes less important in and of itself a people get to know each other.

It's a rare student who doesn't have some problems—scholastically or emotionally—when he goes off to school, and the problems can multiply when a person is disabled. Plentiful counseling services don't hide in ivory towers at SMSC; their goals are to reach the bottom of what *really* bothers the students. Groups of disabled and nondisabled students hash out their hangups about themselves and others.

Who has benefited from the broad opportunities offered at this young learning center? The whole community, undoubtedly, but most of all the handicapped students. They are finding new self-awareness and new abilities to accept and deal with their disabilities. Around the campus the story is told of two handicapped girls who were ridiculed by a man in a Marshall pub. Not pleasant, but a fact of life for handicapped people everywhere. Before their experience as students at SMSC, the young women admitted the comment would have unnerved them. But this time, they were able to realize the fault was with their critic and not with them. "We just felt sorry for that man," said one.

Reading the list of accomplishments by handicapped students at the school, an observer can see that they are not suffering in competition with their able-bodied peers. Paraplegic John Schatzlein, now a graduate, was student body president during his enrollment. Dave Sams, who suffers from a congenital deformity, is manager of the football team. Cerebral palsied John Dose was last year's president of the student judiciary. And disabled students participate in every activity from chorus, to theater, to beer parties.

What will be the result of this preparation to meet the "real world"? Jobs, hopefully. A special placement office for handicapped students can help them find work that relates to their studies. Job counseling is available to place students in internships during the school year as well as in jobs after graduation. Wheelchair repair shop operator Larry Foukas, who is a psychology major, spent one semester working with the Minnesota Governor's Commission on Employment of Handicapped Persons.

According to SMSC work experience coordinator David Cosens, this kind of opportunity is not available for handicapped students at most schools.

As fast as Southwest Minnesota State College is growing—its projected 1975 enrollment is 4,500 students—it cannot help expanding the aspirations of many handicapped young people.

And although the primary goal of the rehabilitation education services program is to get the disabled into jobs for which they are well prepared, the enrichment they can get from the well-rounded, integrated educational environment at SMSC cannot be the least of its accomplishments. ■

Long Term Residential Facilities

The Unresolved Problem For Nonretarded Severely Disabled Adults

JOSEPH FENTON, Ed. D

Still unresolved, is the tragically neglected social and rehabilitation problem of long term residential facilities for nonretarded, severely physically handicapped individuals—a problem that has been chronically facing public and voluntary agencies, parents of the disabled, and disabled persons themselves.

Helpful in surfacing extensive data, documentation, and indepth insights into the problem not heretofore available was a recently published study [1] of 2,565 severely disabled nonretarded persons in need of suitable residential facilities and of young adults living in 500 proprietary nursing homes and public home infirmaries in New York State.

In his *New York Times* column, Dr. Howard Rusk described as follows the problem as typically experienced by many rehabilitation specialists:

In dealing with the problems of the severely handicapped one sees many sad and tragic cases. The saddest and most difficult in the field of rehabilitation are those of the elderly parents of the severely handicapped children.

'We have a wonderful child with a severe handicap. He can walk around the apartment holding on to the furniture. We can understand his speech but no one else can. He listens to good music and reads good books. We have devoted our lives to him. Now, we suddenly realize that our child is 50 and we are 75. What will happen when we are gone?'

This writer never attempts to answer for the answer is too sad and tragic.

The 'child' will go to an institution of some type where he will be mixed with primarily older patients with all sorts of severe physical disabilities and mental deterioration. This will be the unhappiest situation one can imagine. It will be a life of complete boredom, frustration, loneliness, and desolation.

The plight of parents of disabled persons faced with the problem was aptly depicted by Mr. K:

As the parents of a 24-year-old cerebral palsied daughter, we are concerned with her welfare when we are no longer able to care for her. Although paraplegic, she attended school in New York City until age 21. She now attends a young adult rehabilitation and training program.

We, her parents, are now 52 and 48 years of age and plagued with the ailments resulting from more than 20 years of lifting and carrying in awkward positions. Her mother, in addition, is a cardiac victim. We can't help but be reminded of an analogy which was related to us.

It seems that a barber was preparing to apply a hot towel to the face of a customer he had just shaved. Upon removing the towel from the sterilizer, the towel proved to be too hot for him to hold in his hands so he dropped it on the customer's face.

Dr. Fenton is Chief, Special Centers Branch, Office of Research and Demonstrations, SRS.

So it is with us, the parents of handicapped children. Our government agencies, on all levels, find it too complex and costly to handle this problem and so leave it to the ones least prepared, the parents.

For more than 20 years, we have been active in fund raising and planning for the education, rehabilitation, and future care of these children yet find that despite our efforts we today find ourselves in the same position as did the parents of these handicapped children of that time. Are the parents of today's handicapped infants going to find themselves in this same predicament 20 years from now? Is the 'hot towel' still to remain on the parents' faces?

The feelings of entrapment can best be understood by listening to handicapped persons themselves. As an example, a young disabled man in writing on behalf of a group of cerebral palsy adults described the lack of community services and the need for appropriate facilities for those who can no longer live at home because of "worsening conditions."

Our plight is a very desparate one. Most of us have lost one or the other parent through death. We do not want to end up in a State school for the retarded or at the county infirmary. At present, these are the only two places that are open to people in our predicament. We are of keen intelligence and feel this most sincerely. Our needs are great and should not be pushed aside.

A man confined to a city hospital told about the problems faced by disabled persons as follows:

I am 39 years old and have been a patient at the G. W. Memorial Hospital since 1960. I can get about in a wheelchair. I dislike being in a hospital but, because I have no other place to go, I am forced to live in a place where I do not belong. There are many other people here who, like me, have no other place to go. They are not sick and yet are forced to live here.

The hospital was designed for people who are aged, chronically ill, the incontinent, and the mentally confused and incompetent not for the young and healthy but handicapped (physically, that is). There are others like me in similar institutions and in nursing homes which are no more than small, privately owned hospitals. All of these places are totally inadequate for our needs because we are forced to live according to rules designed and written for people who are sick and aged, not for the healthy but handicapped persons. The diets at these places are for the aged and the chronically ill, not for people who are merely handicapped. Are hospitals and nursing homes to become dumping grounds for persons who are handicapped? A hospital is for people who are ill, not for people who are merely handicapped.

Another severely disabled man confined to living in an institutional setting described the predicament as follows:

The need for noninstitutionalized care for the severely disabled is pronounced. If a handicapped person can't care for himself, and his family is too old or otherwise ill equipped to handle him, he must live behind the drab walls of an institution. Here handicapped people eat, sleep, and perform other physical functions of living, but they wither from within. They live in the custodial care of indifferent orderlies, in wards where every now and then someone cries out in physical pain or mental anguish. Others find their accustomed corners and sit in silent torment. These people can live, several to an apartment, off the hospital grounds. They can find, again, the individuality, warmth, and integrity that goes with a home. The by-products of a less clinical atmosphere would be stable, productive, and even tax paying beneficiaries.

Many other case histories and letters forwarded to the study staff from local and public health physicians and nurses, social workers, rehabilitation counselors, and other professionals in the community further documented the diverse and devastating aspects of the problem. Examples of these include such statements as . . .

- The most pressing need for a residential facility is for a 10-year-old boy afflicted with muscular dystrophy who lives with his divorced mother and younger sister. The mother is asking for placement of the boy because she needs (and wants) to work to support herself and her two children. Now that the boy's disease has progressed to the point that he falls a great deal and is difficult to care for because he is heavy and a dead weight, no one wants to take the responsibility for his care. With much difficulty this mother has reached the decision that she wants placement for her son. She needs help and if the boy could be placed in an appropriate facility this mother would be able to cope and participate in help and support.
- There are other disabled individuals whose parents need a rest from their constant care. How much this would improve family solidarity and patient morale! I feel strongly this is the greatest unmet need facing the community and the 10-county area served by this clinic.
- For a number of years I have been loudly proclaiming the need for some sort of State sponsored, tax-supported facility to solve this problem. Few, if any, of these families are financially able to pay for custodial care on a private basis.
- The young child, the teenager, and the young adult are more of a problem because placing such a patient in a welfare home or nursing home environment would be psychologically very bad. Schooling should also be available for those able to profit from it.
- Four of our teenage, cerebral palsy children for whom we were

unable to provide residential care ended up in the State school for the retarded for want of a better place.

In this study, the term residential facility was differentiated from the traditionally associated image of an institution and conceptualized as being a relatively small, homelike, group living, community facility with a stimulating environment which provides wholesome live-in accommodations and offers ongoing health, comprehensive rehabilitation, social, recreational, educational, and vocational opportunities on the premises or easily accessible to it, so as to enable those handicapped persons residing in the facility to live as productive, happy, and fruitful lives as they are capable.

While taking full cognizance that a fundamental philosophical difference exists among and within professional disciplines regarding the appropriateness of residential facilities as a solution to the problem, the study was predicated on the strong belief that whenever possible and feasible a handicapped person's place is at home, with his family, and in his community. At the same time, the study also recognized the frequent existence of debilitating circumstances in the home, family, or community which do not serve the best interests of the disabled individual or his family. In such instances, after careful evaluation of the surrounding circumstances, group residential living facilities may well serve the best interests of all concerned.

Major Findings

The data on the 2,565 individuals in need of suitable long term residential facilities provided ample documentation that the problem is wholly democratic—it affects the well-to-do, the poor, the uneducated and the educated alike. Those affected reflect serious and pressing, complex and comprehensive, individual, family and community health, mental health, social, educational, and vocational problems, and the problems are common to persons of all ages.

The study substantiated that suitable public, voluntary agency or private long term residential facilities for severely physically handicapped children and adults of normal intellect are virtually nonexistent in New York State or in the nation as a whole. If, however, these same disabled individuals were mentally retarded, mentally ill, juvenile delinquents, criminals or criminally insane, they would more than likely be eligible to benefit from a residential program operated by one of the State departments.

The study also revealed that a large number of severely disabled persons are inappropriately placed in long term care hospitals, State schools for the retarded, nursing homes, proprietary homes for adults, and public homes and infirmaries where the environment is un-

Housing Notes

The following items are excerpted from *Newsletter,* published by the Committee on Barrier Free Design, Committee on Employment of the Handicapped:

• Since the Federal law requiring accessibility in publicly-funded projects went into effect in 1968, only 2,243 public housing projects—for low income families—have been constructed according to required specifications.

The New Mexico Governor's Committee on Employment of the Handicapped, meeting in May, went on record with a formal resolution decrying the restrictive interpretation of this law by applying its provisions only to publicly *owned* housing. The Committee feels they should be extended to include publicly *assisted* housing, where federally guaranteed or insured loans protect private investments, and that particularly they should apply to the extensive "Operation Breakthrough" program of the Department of Housing and Urban Development.

When asked why the construction of Operation Breakthrough units could not be in accordance with barrier free design, a HUD regional official replied that this question was brought before the architectural and legal staff and that the concensus was that Public Law 90–480 was directed primarily to public buildings. "Residences designed for private ownership were exempted from this provision. Implementation of a barrier free design for all residences, based on today's building costs, would be prohibitive for all units designed for low income families."

• The trouble with some State legislation is that the provisions contain no enforcement or penalty clauses. The citizens of Omaha, urged on by the Great Plains Chapter of the Paralyzed Veterans of America, decided they wanted something with more teeth than their State law offered. The City Council approved an ordinance amending the building code and making it applicable to all buildings, including privately owned buildings, where the "public is invited." To insure that features of accessibility are designed into all such buildings, the ordinance provides that violation of the provisions shall be deemed a misdemeanor and conviction shall carry the penalty of a fine not to exceed $500 or imprisonment not to exceed 6 months in jail, or both. ■

stimulating and the population consists primarily of aged persons. It also showed that most in need of residential facilities are currently living at home where the problem of physical disability is creating severe physical and emotional strain on the individual and his family and that many are living at home because few families can afford the maintenance charges at existing inappropriate institutional-type facilities, no less pay for those facilities more suitable to their needs, even when these facilities do exist.

The study revealed a number of other findings: most persons now in residential facilities are recipients of public assistance which contributes toward the monthly charges; only a very small number are financially able to pay the charges, while a large number at home don't qualify for public assistance, yet cannot afford to pay for residential facility placement; there is parental ambivalence about having children live away from home which would be overcome if appropriate facilities were available in close proximity to their homes; voluntary agencies do not have the financial resources to establish or maintain residential facilities; there is no federal agency or program that has responsibility or is providing leadership toward resolving the problem; no State agency has been willing to assume the responsibility for promoting a residential facility program; there is an urgent need for the State and the Federal Government to become actively involved and provide the leadership necessary to develop a residential facility program for severely, physically disabled nonretarded persons.

The potential problem was initially conceptualized as belonging solely to very severely disabled persons who were to a large measure dependent upon others for personal care and independent living activities. Yet another segment of the handicapped population was identified as being capable of profiting from other types of living arrangements.

This second group includes those who may have some mobility with the use of wheelchairs, braces, crutches or canes and can function independently with a limited amount of self-help assistance. Many could live alone or with others in apartments, private homes, or motel-type facilities if there were no architectural barriers to contend with or if minor structural adaptations were made. Many in this group are also capable of self-support through gainful employment in industry or sheltered workshops, if, in addition, some form of special transportation provisions are made available.

Of special significance were the services for the study group, reported as "needed but not receiving." They were, in order of rank: recreation, vocational evaluation and counseling, social services, transportation, occupational therapy, friendly visitors, psychological services, physical therapy, schooling, attendant care, homemaker services, home-care program, speech and hearing therapy, physical followup, medical evaluation, public health nursing, general hospital care, and 16 other miscellaneous services.

Five hundred and sixty-six persons over age 18 were reported as never having been referred to the State Division of Vocational Rehabilitation; 342 were in need of this service but had never received it; 106 had been rejected from VR services as not being eligible; 101 had received VR services; 103 were receiving VR service at the time of the study.

In another realm, 1,192 were not participating in any recreational activities; 383 participated occasionally. The lack of community recreation programs was the chief reason for not participating while lack of transportation was given as another important reason.

Many other significant areas of inquiry were pursued in the study. Detailing them here would be too lengthy. They are available in the report listed in reference one.

Recommendations

Residential facilities were recommended for physically disabled, nonretarded of two severity levels: the very severely disabled (those largely dependent on others for assistance) and the severely disabled (those who to a large measure can manage their activities of daily living). In addition, a series of 18 recommendations were made which have the potential for transforming the life style of thousands of persons from one of social isolation and dependency to an environment where it would be possible to live with dignity, share experiences, socialize, recreate, and communicate with others of similar interests and intellect—where medical and psychosocial services are available, wholesome family and community relationships maintained, opportunities to develop educational and rehabilitation potentialities afforded—and for those capable, participate in industrial or sheltered employment experiences.

While the data in this report was obtained by studying severely disabled persons in New York State, the problems disclosed are universal and the recommendations applicable nationwide. Of sorrowful significance, however, was the noticeable disparity between the long standing recognition of the problem and the lack of initiative, involvement, commitment or leadership taken by the Federal Government, the State or any of its agencies to spearhead the kind of effort required to activate a solution to the problem of long term residential facilities for severely disabled nonretarded persons.

Reference

(1) Fenton, J. and Ayers, R. E. *Residential Needs of Severely Physically Handicapped Nonretarded Children and Young Adults in New York State.* Rehabilitation Monograph No. 46. The Institute of Rehabilitation Medicine, New York University Medical Center.

Therapeutic Housing

CHARLES RICHMOND, ACSW

Supervised housing is an essential adjunct to effective rehabilitation of the patient in the community. All too often the neglect of such supportive services has caused rehabilitation efforts to flounder. Many models of residential community care are in use today, including family care homes, boarding homes, foster homes, group homes, and halfway houses. Unfortunately these terms are used interchangeably so that the picture is often confusing and blurred.

All of the models of residential care mentioned above, with the exception of halfway houses, operate by accepting into a private home paying "guests" referred by public social agencies or hospitals. The usual purpose of these homes is to provide a long term domicile, care, and supervision for those unable to care for themselves. Generally the patient is supervised by a caretaker, usually the owner of the home, who in turn is provided consultation and supervision from a social worker, usually attached to a social welfare agency or hospital.

The term used to describe a particular type of residence, whether it be foster home, boarding or family care home, depends a great deal on the definition of the State or local licensing authority if there is one, or, if the home is not licensed, on the whim of the caretaker-owner. Many of these caretakers certainly perform a valuable service, namely shelter, food, and concern; however, today many boarding home operators regard their residences as halfway houses. But despite this current vogue, these houses are not halfway houses, since they provide no formalized or systematic program of rehabilitation. They are, rather, simply "sheltered" rooming houses.

Exceptions do, of course, exist. There are boarding home operators who, on their own or in conjunction with the guest's social worker, do have a rehabilitation emphasis. Such operators encourage their guests to find sheltered or competitive employment, attempt to increase their social activities, and even encourage movement to more independent living.

The Halfway House

While boarding family care homes are the world's oldest form of housing and care for mental patients, the halfway house, which shares some similar purposes but has a very different operational structure is one of the most recent. Halfway houses for the mentally ill and socially disabled developed slowly but consistently during the early 1950's, culminating in a great surge in the late 1960's. This surge probably received its impetus from the mass exodus from State hospitals, the advent of psychotropic drugs,

---

Mr. Richmond is executive director of Mental Health Recovery, Inc. This paper is based on a chapter on therapeutic housing contained in the book entitled, Rehabilitation in Community Mental Health, *and issued by Jossey-Bass, Inc., publishers.*

and the development of community mental health concepts.

The survey for the Joint Commission on Mental Illness and Health located only seven halfway houses in 1959, all established since 1954.[1]

Now there are more than 250 halfway houses in the U.S. Due to an endless variety and the lack of a commonly accepted definition, however, it is extremely difficult to determine their exact number. There are, for example, houses for formerly hospitalized mental patients; houses for preventing hospitalization and houses which combine both purposes; there are houses for alcoholics, ex-convicts, drug abusers, addicts, adolescents, the retarded; there are houses for men or for women and co-ed houses. There are houses which define "transitional" as a few months and others as a year or more.

Rehabilitation approaches vary widely, also. In fact, some houses are little more than boarding houses, with little or no rehabilitation goals. Most halfway houses, however, share certain common functions: 1) residence, 2) transition, 3) socialization and resocialization, 4) vocational assistance, 5) ancillary treatment and rehabilitation services.[2]

Halfway houses offer a group living experience which is designed to produce changes in social behavior and ability to function more independently in the community.

It is the differences from the hospitals and institutions which are their essential ingredients. The halfway house provides a protective subsociety in a family-like, nonmedical setting. The smaller group composition, the informal but structured atmosphere, the emphasis on health rather than illness, and the increased contact with the mainstream of the community life—all these factors together create a milieu which cannot readily be duplicated, even in the most progressive and modern open door hospitals. Halfway houses are not self-contained societies as are most mental hospitals; residents must relate to the community in order to obtain medical care, work, schooling, recreation, etc.

The transitional nature of residency at halfway houses affirms the expectation that residents will move toward a more independent existence. How long a resident remains varies, depending upon the expectation of each house. Some houses pride themselves on a brief stay of perhaps 3 to 6 months, while others consider this period much too brief to accomplish their aims. How long a resident stays also depends largely on what the referral source, the staff, and the patient hope to accomplish. What other residential resources are available in the community also affects the length of stay. Where there is ample housing in the form of apartments, residence clubs, rooming houses, and the like, the move is greatly simplified. Where there is a paucity of ordinary living accommodations, residents who otherwise would be ready to move on, remain longer than necessary.

Wechsler [3] points out an essential feature which distinguishes the halfway house from the family care or boarding home—the use of the group as part of the rehabilitation process. The use of milieu therapy, where the group serves as an agent of change, facilitates socialization experiences. According to Wechsler, "The halfway house may be considered to be a sheltered social environment, within which there is a tolerance of behavior which would be considered deviant elsewhere. The resident may be freer to act and to try out new rules and behaviors within this sheltered setting. However, the resident group may act to modify the individual's behavior to make it conform to group norms. As the individual drops patterns of behavior disapproved of by the group, and adopts behavior which is encouraged, it is hoped that this learning will be generalized to social interaction outside the house. The resident group thus acts to socialize or re-socialize the individual." [4]

Halfway houses draw from a multitude of treatment modalities, including milieu therapy, the therapeutic community, behavioral modification, and reality therapy. Indeed, there is no universal treatment model. There is one common ingredient in any effective house, however, and that is the expectation that a resident can and will achieve a higher level of functioning.

The effective halfway house fosters attitudes so that residents see themselves as potentially healthy, rather than sick people. Residents are expected to mobilize their strengths, to realize their full resources and potential. Regressive and bizarre behavior is dealt with on the basis of its effect upon others as well as its meaning to the person. Adult and socially responsible behavior is expected from residents and

opportunities for such behavior are provided. The concept of the "high expectation halfway house," as distinguished from a low-expectation or "nurturing approach" [5] differentiates the dynamic and successful halfway house from those which are halfway houses in name only.

A high expectations philosophy is communicated to residents both verbally and nonverbally. For example, at El Camino House in San Mateo County, California, the physical milieu communicates informality and homelike atmosphere. Its homey living room, dining room, recreational space, and sleeping quarters appear comfortable and lived in. The social milieu communicates: "while here you are a person not a patient. . . . We are interested in your abilities, your strengths, talents. . . . We expect you to conduct yourself as any ordinary citizen; usual courtesies and consideration toward others is expected."

Individuality, autonomy, and involvement in the house program are highly valued. Deviant behavior is tolerated within limits. Behavior which is overtly self destructive, destructive toward others or infringing on the rights of others is dealt with as unacceptable and irresponsible. Residents are expected to participate actively during daytime hours in some positive endeavor, whether it be vocational training, school, work, day treatment center or regularly scheduled volunteer activity.[6]

Other expectations are that the resident handle his own prescribed medications, that he arrange for his own transportation, and that he participate fully in the cleaning, maintenance, and cooking within the house. The message is that he is capable; he is able to function in the community or at least that he can learn to do so with encouragement and support.

Socialization and resocialization are promoted and communicated through the physical and social milieu, through the staff and the house expectations, rules, policies, rituals, and through the culture which is perpetuated by both residents and staff.

Vocational Assistance

Work has long been recognized as a major element in rehabilitation. It places the person in a structured social situation and provides an opportunity for conformity to important societal norms. Many halfway houses emphasize the provision of vocational assistance as a primary service of the facility while most others regard helping the resident to find and keep employment as a very important secondary goal.

Since halfway houses are dedicated to assisting the reintegration of the patient into the community-at-large, it is quite natural that they would concern themselves with vocational endeavors. While the socialization and resocialization experiences of residents just described may assist their ability to succeed on a job, the halfway house is in no way a substitute for a sheltered vocational workshop.

Halfway houses by means of the socialization process should provide "life habit training," through resident involvement in those activities that are necessary to the everyday operation of the house, such as housework, light maintenance, and cooking. These activities do not, however, prepare residents for most types of jobs available in the community but prepare them for the everyday process of caring for themselves and their property.

The assistance with vocational pursuits which is provided takes many forms and depends to a great extent upon what other vocational resources are available in the community. Where there are vocational counseling or sheltered workshop and employment services, such resources should be used. The halfway house attempts to motivate the person toward some constructive use of his daytime hours and directs him, when ready, toward use of available vocational resources. The house encourages his vocational activity and maintains a liaison with the vocational resource to insure that the goals of the house and the vocational agency are compatible. In fact, many houses achieve a very close working relationship with vocational rehabilitation services.

In areas where community vocational services are not readily available or accessible, the halfway house often takes on a much greater responsibility for vocational planning. Here, work-related activities are built into its structure. This may take the form of a staff member, such as the director, conducting prevocational and vocational counseling in the house, leading role playing groups related to job interviews, and sometimes assisting in finding volunteer work, work experience placements or actual competitive employment.

Scattered or Satellite Housing

Raush and Raush,[7] in an excellent study of halfway houses, state: "What can be done to serve those residents who may never be able to live independently but who do not require hospital security

Four Mental Health Recovery patients live in modern, 2-bedroom apartment. Rented quarters are furnished with donations; they are surprisingly attractive.

remains a pressing problem for the halfway house administrator." They suggest planned group discharge of patients from the halfway house to permanent and semi-custodial "quarterway houses."

They further suggest facilitating transition to the community by a series of graduated steps, possibly into joint living arrangements with minimal or no supervision. "A potential network of halfway houses, three quarterways and quarterway houses," say the authors represents an alternative to the mental hospital. ". . . A network of such houses with opportunity for mobility among them offers a more appropriate structure and far greater opportunities for rehabilitation and reintegration than does the mental hospital." Indeed, over the past 5 years, just such innovative extensions of the halfway house are emerging.

Extramural housing, where patients live in small groups without live-in staff, but with some supervision may in fact be considered the current "movement" in the field. And this movement is not confined to programs serving the psychiatrically disabled.

The Satellite Housing Program in San Mateo County [8] was initiated primarily due to the paucity of adequate, economical housing for graduates of El Camino House, and the need for systematic followup and long term supports for many of the more chronic patients. Gradually an increasing number of patients referred from hospitals and other psychiatric agencies were placed directly in small housing units (apartments, duplexes, and small homes) scattered throughout the county, bypassing admission to the halfway house.

The availability of both halfway house and satellite housing units enhances flexibility of placement choice. The existence of a large number of community apartments increases the possibility that roommates compatible with one another in terms of age, personality, and level of functioning can be matched. Between three and six persons of the same sex reside together, do their own shopping, cooking, housework, etc.

Staff specifically assigned to the Satellite Housing Program make themselves available as needed for

guidance and counseling of residents, both individually and in groups. Staff are also available on a 24-hour, on-call basis for emergency situations.

Generally the residents of three or four apartments comprise one stable group. They meet with staff a minimum of every 2 weeks. Groups are hosted by residents on a rotating basis in their own housing units. Interim group meetings are often held by the members of a single housing unit without staff present. Liaisons are maintained with therapists and agencies involved with the patient, through such means as the day treatment center or sheltered workshop. Often early intervention and avoidance of need for rehospitalization is precipitated by a call of concern from a roommate. Occasionally a patient in significant crisis may be removed from his apartment and placed for a brief period in El Camino House as an alternative to hospitalization.

The program provides both transitional and long term housing and aftercare services. For some residents, the satellite housing units become their permanent homes, with varying amounts of ongoing supervision. Sometimes the agency is simply on call—the residents having, for all intents and purposes, reached independent living. Others leave the program to live entirely on their own.

Similar to El Camino House, the Satellite Housing Program is conducted as a high expectations setting. The residents of the various housing units contract with the agency to remain in outpatient therapy, to attend the regularly scheduled meetings, and to occupy daytime hours constructively.

Group, family care, and boarding homes have been with us for centuries, and the thinking behind them usually includes live-in, 24-hour staff supervision. But the concept of disturbed persons living together without live-in supervision is not new to modern psychiatry either, as Joshua Bierer [9] established a self-governed "hostel" in England more than 15 years ago.

The use of small, semi-independent, but supervised housing, is an emerging development in the field of aftercare services and in some cases can be an effective alternative to hospitalization. It also holds potential for providing an alternative for some patients to the use of family care and custodial boarding homes. In addition, finding apartments, duplexes or cottages for small groups of patients is a simple task, indeed, when compared with the work involved in recruiting adequate family care and supervised boarding homes or establishing halfway houses. No zoning problems or special health regulations are involved, since the use of such dwellings is not significantly different from the use made by any other citizen.

Satellite housing accommodates 5 patients in this modern 3-bedroom home.

In conjunction with halfway houses, the scattered housing unit program provides a fuller range of alternatives and makes it possible to offer rehabilitation housing not on the basis of what is available, but more on the basis of patients' needs, goals, and level of functioning.

New Directions

The halfway house was originally designed to assist patients to cope with the arduous transition from long periods of hospitalization. It was needed in order to prevent exacerbation of client illness and to help the client remain in the community. To the extent that the community mental health center movement is successful in reducing long periods of hospitalization, the original role of the halfway house may further shift from that of providing a bridge between institution and community to that of serving primarily the acutely disturbed as an alternative to hospitalization.

In response to the paucity of community based "open-door" services for adolescents, privately sponsored agencies have initiated transitional residences for that age group. Thus, the private voluntary agencies, which specialize in community based residential programs, seem to have taken the lead in devising viable alternatives to hospitalization, new modalities for the prevention of chronicity, programs to combat drug abuse and delinquency, and therapeutic accommodations for partial families.

Glasscote, et al.[10] state, "There are large numbers of inpatients—perhaps as many as 100,000—who might well be able to live in the community, provided there were openings for them in halfway houses." This would indicate the need for several thousand halfway houses, rather than only about 200. The question may be asked, however, whether halfway houses as aftercare facilities in their present form are not already outmoded since they cannot even begin to meet this extent of need. The more than 200 or so small, intimate houses which accommodate between 12 and 20 residents (perhaps three times that number over a year's period), located primarily in urban areas; no matter how attractive in style and noble in purpose, cannot hope to serve more than a handful of the total number of persons requiring service, and then in their present form, serve only one segment of that population—the single, divorced or otherwise unattached person.

But halfway houses are difficult to establish and if they are to become a more significant resource in providing services to the mentally ill, emotionally disturbed or socially handicapped, either some conditions affecting their establishment, i.e., funding and zoning, must change or the model as we know it must change.

With regard to the provision of funding or "seed money" which would stimulate and facilitate the establishment of more halfway houses, such funding, if it is to have any real impact on the movement would have to involve large amounts of money, distributed in grants from governmental sources, either State or federal. Unfortunately, this does not appear very likely at this time, despite the pronouncements for community care of the mentally ill. Even if such funds were forthcoming, the danger of deterioration and bureaucratization of the halfway house movement cannot be overlooked. As Apte[11] pointed out, the provision of such funds under the National Mental Health Act in England led to the proliferation of a large number of halfway houses which were, in time, largely unused, poorly staffed, nontransitional in nature, and often lacking in dynamic and quality treatment procedures.

Community attitudes towards the housing deviant groups in the community, although changing, are not changing quickly enough to ease the situation. It can safely be said that upon initiation all houses encounter some level of opposition. More permissive zoning ordinances, although quite desirable, are neither likely on any large scale nor a guarantee of community acceptance.

The relative ease with which scattered housing programs can be established and the interest in this model of care, as demonstrated by the numerous agencies which are now either operating or planning to initiate similar programs, point to the possibility of alleviating the problem. Will transitional houses, then, still be necessary if sufficient satellite housing is developed? We believe they will continue to be necessary since there will always be patients who will require, at least initially, the special family-like environment and proximity to staff of the halfway house prior to moving to more autonomous surroundings, just as there will always be patients who require hospitalization.

Scattered or satellite housing, however, can often substitute for the halfway house, and it is conceivable that the development of such programs could diminish the current urgent need for more halfway houses. The more alternatives that are available, the less reliance there will be on any one model of care. Flexibility of placement is greatly enhanced thereby.

Halfway houses in combination with scattered, supervised housing hold the promise and potential of serving a much larger number and wider range of persons and groups than hitherto served. We hope the movement continues unabated.

References

(1) *Action for Mental Health,* final report of the Joint Commission on Mental Illness and Health. New York: Basic Books, 1961.

(2) Landy, D., and Greenblatt, M. *Halfway House: A Sociocultural and Clinical Study of Rutland Corner House, A Transitional Aftercare Residence for Female Psychiatric Patients.* Washington, D.C.: Rehabilitation Services Administration, Department of Health, Education, and Welfare, 1965.

(3) Wechsler, H. "Halfway Houses for Former Mental Patients: A Survey." *Journal of Social Issues,* 1960, 16, 20–26.

(4) *Ibid.*

(5) Wilder, J. F., Kessell, M., and Caulfield, S. C. "Followup of a 'High Expectations' Halfway House." *American Journal of Psychiatry,* 1968, 124, 1085–1091.

(6) *Handbook of Community Mental Health Practice.* Lamb, H. R., Heath, D., and Downing, J. J., Eds. "Transitional Housing" C. Richmond, San Francisco: Jossey-Bass, 1969.

(7) Raush, H. R., and Raush, C. L. *The Halfway House Movement: A Search for Sanity,* New York: Appleton-Century-Crofts, 1968.

(8) Richmond, C. "Expanding the Concepts of the Halfway House: A Satellite Housing Program." *The International Journal of Social Psychiatry,* 16, 1970, 96–102.

(9) *Therapeutic Social Clubs,* J. Bierer, Ed., "A Survey of Social Club Therapy." Bierer, J., London: H. K. Lewis, 1948.

(10) Glasscote, R. M., Cumming, E., Rutman, I., Sussex, J. N., and Glassman, S. M. *Rehabilitating the Mentally Ill in the Community,* Washington, D.C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1971.

(11) Apte, R. Z. *Halfway Houses: A New Dilemma in Institutional Care,* London: G. Bell and Sons, 1968.

The Dynamics Of Residential Living

KARL GRUNEWALD, M.D.

There is an observation made by persons who work in institutions that severely retarded persons appreciate a "small environment" where there are few interactions with other people. Observations show the positive effect on severely retarded persons when they are moved from a large ward of 20–30 persons to a small group of 10 or less (preferably 5–8). Their reactions suddenly become predictable. They recognize and grasp reality. From such observations psychologists have formulated the *principle of the small group.*

Thus, an influence for favorable development is to be found partly in the small number of interpersonal relations forced upon the retardate. Stimulation rather than frustration results. The second part of favorable development comes from the homelike atmosphere and equipment of the room and of the unit to which the room is connected.

The homeliness—or homelikeness—may need to be modified when considering more or less permanent medical needs and when considering necessary technical arrangements for persons with handicaps additional to their retardation.

What is important when planning for residential living is that the starting point be an environment normal, homelike, and small.

Learning And Application

Psychologists teach us the importance of a clearly-structured learning situation, and research shows us how much we can achieve with profoundly retarded persons by individualizing and simplifying the influence techniques. Psychologists and educators are producing increasing amounts of carefully programed and systemized learning sequences based upon exact pretraining analysis of the level each retardate has reached in his various capabilities. These clearly-structured sequences must be realized in both individual and group situations.

Applications of these structured influences must be made in a small group and in an environment very rich in stimuli, e.g. in a surrounding that contains all that is found in a normal home and which makes possible normal self and group activity. In these

Dr. Grunewald is Director of Mental Retardation Care Services, the Swedish Board of Health and Welfare, Sweden. *The article is based on a paper that he presented at the First Regional Conference of the United Kingdom Committee of the World Federation for Mental Health. The conference was held in Dublin, March 27–April 1, 1971.*

situations the child or the young persons should have the opportunity to experience what the psychologists call "transfer" to related situations.

The point is that the pupil does not have to change his conceptual structure in order to apply what he has learned, as these must be basically the same in one situation as in another. There must be slight concrete changes, however, in order to be transferable to increasingly different situations. This transfer ability determines the potential for development of intelligence and eventually for the integration of different abilities at increasingly higher levels. Thus, good adaptation requires transfer training; transfer requires a small envionment rich in stimuli; and individualized, well-structured, and meaningful influence techniques are required to achieve the greatest benefit from the stimuli of a small environment.

This application milieu must be a socially real and concrete environment. It is not possible to build up substitute situations within institutions. The retarded individual needs training in a situation identical to that in which he is going to function, yet at his own pace. This means that we must offer our severely retarded persons social environments and situations where they may apply freely and in a natural way that which they have learned in the specific instructional situation. This application concept is an important consideration when determining where in our community a hostel or residential home for retarded individuals is to be located.

Consequences For Residential Planning

Socially-real applicational environments have already been made in Sweden. We have built a residential home for severely retarded children that is situated in a normal, private residential area in a town. The children can watch traffic from the windows or be taken outside onto the sidewalks to experience natural light and sounds, to play in the yard or exchange greetings with neighbors and passersby. They have the opportunity to visit shops along with the staff members. Thus they have some of the opportunities a normal child experiences in a close community.

Another home, partly for severely retarded children less than 7 years of age, consists of three houses in an ordinary block of row houses.

These examples of placing smaller residential units in the centers of our communites are only hints of how to give the most severely retarded children and adults a concrete and close educational environment.

The Planning Of Comprehensive Services

We cannot run systematic programs of guidance without considering the emotional ties of the child or young person. Services of the future will support parents to a much greater extent than presently. Those children who cannot stay at home continuously will at first be taken into residential units for short-time care and for observation or relief care. Educators will teach in the home those children who cannot come to a group. Parents will be offered courses individually or in groups.

We must plan our services by starting from the normal community. The flow and development of increasingly comprehensive services should be from without the institution to within. This means that specialists who organize services and supervise staff must not be tied to institutions. All services for retarded persons must be regarded as of equal importance and the priority for serving residents in a residential home on a 24-hour-a-day basis must be broken. The development of care at home and other kinds of day care will benefit.

This concept of serving the retardate in the community also means that we should put greater demands on all kinds of specialists whose skills we can use in our provision of services. We should buy such services as much as possible instead of building up a specialists' service of our own. We need exactly the same specialists for retarded persons as for other children or adults.

The emphasis on provisions for services should be transferred to the community. The retarded individual should be regarded only as one among all others who needs some form of support or service. It is not enough to normalize the retarded person, but we must also normalize our services and the entire organiation of services. In reality, retarded persons are part of the total community and can help us in a process of de-intellectualization that is necessary for the good of all.

When planning and forming future services for mentally retarded persons, two important factors must be considered. One is that we apparently will have fewer severe retardates in the future. According to certain Swedish statistics we have a concentration of the most severely retarded in the age group

15 to 25 years old. In older groups there appears to have been a very high death rate. With the age groups below 15, we have been more active in habilitation and have given better prophylactic care. Possible contributory causes to the concentration of severely retarded in the 15–25 year age group are that these persons did not benefit from recent improvements in premature care which now saves the lives of many children and the widespread use of penicillin and other antibiotics. In the future I think we will have a decreasing number of additional severely retarded people. At the same time we can expect improvement in the functioning level of those whom we now serve.

The second factor involves consistency in separating residential living, occupation, and leisure time. We want a geographical distance, for instance, between the school and the residential home as well as between all other types of living and the daily occupation. We also want to use the community's leisure-time and recreational facilities. Our goal is to have leisure time spent out in the community, preferably individually but otherwise in groups.

The Dynamics Of Living

The dynamics of residential living are initiated and developed by our creation of small heterogeneous environments so rich in stimuli that the retarded person assimilates the benefits of the environment and can advance to a new and even more normal setting. In the future we will need many relatively small units located in the middle of society, which are more or less specialized for the functional level and actual needs of the retardate.

This means that the retarded person, as he progresses, will have to move more often than he has had reason to so far. Movement is regarded as a disadvantage by many people who think it is good and a matter of security for the retarded person to live and stay in one place for his entire life. We ourselves, however, often experience economic or personal development and renewal when we change places of work and residence. So the experience should not be specifically restricted to the nonhandicapped.

The Case With Children

In the future children will not have to live in special residential homes but will live at home to a greater extent, or as an alternative in 5-day group

Dear John

Most architectural barriers
I've learned to take in stride,
Those steps, those curbs, those
revolving doors
That make me stay outside.

I can live with water fountains
That are level with my ears;
And I have never used a phone booth
In all my many years.

But when it comes to restrooms
It really is a blow—
It's knowing that when I've gotta
I ain't gonna get to go.

I burn the rubber off my wheels
I can hardly wait
But my chair is thirty inches wide,
The John door, twenty-eight.

Some plead for civil justice
When they are set upon
I ask for only one freedom—
The right to use the John.

I've thought about reforming
To change my wayward ways—
To become a model of deportment
For the remainder of my days.

But when I get to heaven
And sit before the gate,
Will St. Peter say, "You're thirty
inches wide,
Our John door, twenty-eight?"

—Carl F. Odner

homes (weekends at home) or in 7-day hostels. Today we have had good experience with group homes housing 4 to 6 children in each unit, located in ordinary flats in apartment buildings and private houses.

Our architects must design future group homes so that even the most severely retarded children can live in them. There is no longer any reason to separate these children from the less-retarded. The special medical services they need can be given in one house as well as in another. Of course a certain age differentiation will be needed, but, in principle, one should strive towards heterogeneous family-like groups. That children should not live in the same area as adult retardates I see as self-evident.

Apart from these group homes, places (units) in hospitals are needed for those retarded children who also are ill. These hospital units should be used for short-time care for children who otherwise would live in group homes or in their own homes, and also for longer term care for the multihandicapped, especially those who are seriously physically disabled and epileptic. The care in these hospital units would be integrated with medical care for children in the community. If there is a demand for a whole unit then the unit should be attached to a facility for nonretarded physically disabled children.

The Case With Adults

Trends now developing in planning for adults will prove that we shall be more and more able to manage with two forms of collective living: group homes situated in ordinary apartment buildings and local hostels. For backup or supportive services, we need available places in hospitals for medical and psychiatric care—particularly short-time care. Presently there is the risk that we may be building residential homes that are too large which, because of their size, are segregated automatically from the community, and that we are building too many hospital units that tie the retarded persons to a level of dependency that is much too high.

In Sweden we have a five-year plan for developing different living possibilities.* According to this plan the percentage of adult retardates living in hospitals for the retarded will comprise only 12 percent (rather than the present 19 percent) of all adult retarded persons in need of residential care. Our special hospitals at present average 300 beds each and our central residential homes (generally one in each of our 25 counties) average 200 beds each. When the 5-year plan is fulfilled about 35 percent of the adults will live in this type of residential home.

The next step in the normalization process is living in a local hostel organized as an annex to a central residential home. There are a little over 100 of these in Sweden. Their number will increase in the next few years, and they will house on the average 48 people each. In order to be economically stable these hostels cannot have less than approximately 25 residents each, which still means that they are relatively small homes, and—being community centered—will have a fairly good potential for promoting social relations. Thirty-eight percent of all adults—the greater part of all of our adult retardates—will live in these local residences.

Our greatest achievement in collective living at present is with the group-type home. In only a few years the number of such homes has increased from a handful to some 90 homes. The average number of beds per home is eight. Around 6 percent of the adult retarded people live in these homes today, but in 4 years this percentage will increase to 14 percent. This means that we then will have 2,200 adult retardates living in such small group homes, most of which consist of regular flats in apartment buildings, rented by the county administration on the same conditions as for private tenants. Renting, by the way, contributes to quick availability of this type of home.

In the future there will be different types of group homes from those housing 3 to 4 persons and practically no staff to those with 7 or 8 retarded persons in each home. Small apartments should be concentrated in one residential area. Together they constitute a Group Home with a supervisor who assigns staff as needed. We want to avoid "night personnel" in group homes for adults.

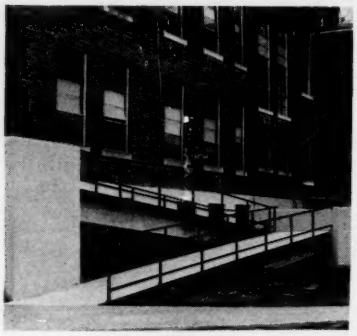
The creation of different normalized environments makes possible dynamic living where the retarded person is stimulated by being a member of a small group. Here the adult retardate will be able to develop simply by living.

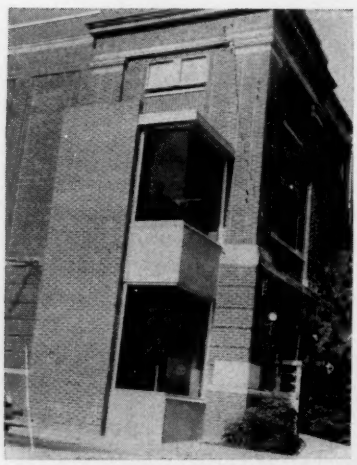
In this manner, new norms and organizational forms may be formulated that tear down what earlier generations have built with much toil and economic hardship. With humanity, however, it is a maxim that rigid and sterile order is broken by creative unrest and the establishment of a new order requires new means. Indeed, in our society, this is living itself. ■

*Sweden has 8 million inhabitants of which 0.37 percent as retardates receive some form of services. 0.20 percent live in 200 24-hour-homes and hospitals (group homes excluded).

Architectural Barriers Removal

BRUCE J. TILLMAN, PH.D





Top and side view of ramped classroom building. Bottom photo, exterior elevator—add-on to an existing building.

In June 1969, East Central State College in Ada, Oklahoma, and Oklahoma's Social and Rehabilitation Service combined their efforts in developing an architectural barrier removal model demonstration site and information center. Specifically, the center was to concentrate its efforts on barrier removal in a typical college setting with buildings varying in age from a few months to over one-half century and with a variety of architectural styles.

In addition, the campus selected presented a topographical problem. The living area is located at the foot of an escarpment, and the classroom area is located some 60 feet higher on the upper campus. In short, this middle sized campus presented, in cameo fashion, a cross section of the terrain and architectural and attitudinal problems that confront any institution attempting to modify its campus so that the severely handicapped can avail themselves of its facilities.

The 1st year of the 3-year SRS-supported project was devoted largely to physical barrier removal, and the 2nd and 3rd years were planned as "demonstration years." SRS has sponsored several barrier removal programs across the nation. Its resources have been well-placed in such ventures. On-site barrier removal, however, was incidental to the central purpose of this project.

SRS officials at the State, regional, and national level realized that it was impossible for them to sponsor barrier removal throughout the nation. The decision was made to make this particular site into a demonstration center and to invite leaders from education, governmental agencies, business, religion, and civic areas to visit the campus. The purpose of these "on-campus" barrier removal seminars was to impress the participants with the need for barrier removal and also to show them some of the techniques of modifying an existing facility.

State and national legislation has done much to eliminate barriers in new buildings, but, unfortunately, most industrial and public buildings that will be used during the next 50 years are already constructed. For this reason, effort must be exerted to impress on industrial and public officials that barrier removal in the "next building" isn't enough. Barriers must be removed from "now buildings" as well.

During the first 2 years, 350 persons visited the campus as part of seminars. They represented industry, education, State and local governments, as well as delegates from Washington. The approach for the 3rd year was changed from seminar-participant to a task force system. This change was the result of a meeting held for the Oklahoma City chapter of American Institute of Architects which demonstrated the need to educate architects about federal and State legislation requiring new construction to be barrier free.

Consequently, efforts have been made this last year to take a "task force" from the college to visit schools which have departments of architecture so that the upper level students would become aware of the barrier problem and legislation regarding it. The task force consists of an architect and handicapped East Central students who have seen the

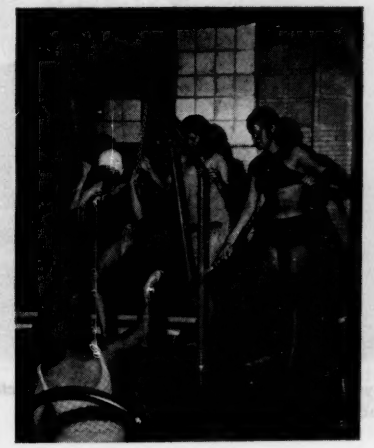
Dr. Tillman is Vice President, East Central State College, Ada, Oklahoma. He is also project director of the program described here.

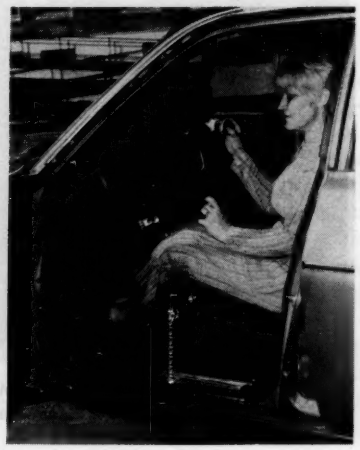
campus both before and after the barrier removal program was implemented. Their voices have been most effective in presenting the need for the problem to be the concern of all who are in administrative roles where handicapped students, clients, patients, customers, or citizens are involved.

We have learned much about the problem of renovating institutional facilities for the handicapped—the primary goal of the project. Additionally, we have gleaned much information that we did not anticipate. We found, for example, that the present provisions for helping severely handicapped students through the public school, such as homebound teachers or telephone communication to the classroom, are totally inadequate; over 80 percent of our handicapped students were reported as doing unsatisfactory work at the end of the freshman year. This academic failure did not result from a lack of innate ability, but, rather, reflected academic deficiencies stemming from their being denied typical public school experience.

Other disturbing ancillary findings were that the typical practicing architect is totally unaware of State and federal legislation designed to eliminate barriers. Furthermore, we found little enforcement of barrier-related regulations at either the State or national level.

Problems still exist for the handicapped. Society, however, is becoming aware of them, and the first step in problem solution is identification. We think that the East Central State College experience is a positive step forward in identifying the need for barrier removal. As an example of what can be done, the project provides the model for implementation elsewhere. ■





Top photo, an attractive "garden ramp" connects upper and lower campus. Below, left, swimming pool where handicapped students can also enjoy the water. At right, disabled student learns use of hand controls in driver education course.

New homeowners are congratulated by Msgr. Richard M. McGuinness, Assistant Director of Mount Carmel Guild, and Tony Surano, President, Carteret Savings and Loan Association.

Brings Unprecedented Hope and Opportunity

JOHN F. MULVIHILL, JR.

Owning a house and establishing a home is a dream shared by many Americans, and over the years many Americans have been able to make it a reality. Latest figures from the Department of Commerce show that 35,659,159 families own the homes they live in. This represents approximately 54 percent of all families in the U.S.

For some families, however, the concept of owning that small parcel of land they call their own, with a house they call home, is as foreign and remote as traveling to the moon was only a decade or so ago. And yet, today we are traveling to the moon and back regularly—and at least 47 greater Newark, New Jersey families who never dreamed of owning a home are making monthly mortgage payments regularly.

Never in their Wildest Dreams . . .

The Smith family is a good example. Mr. and Mrs. Smith, married 17 years, in their late 30's, with seven children ranging in age from 7 to 16, have lived in inadequate and substandard housing all of their lives as did their ancestors for many generations past. Mr. Smith is a semi-skilled laborer, earning just under $100 a week. The family has an extremely poor credit rating as a result of being caught up in the cycle of borrowing and buying at high financing costs. Mrs. Smith has received training as a nurse's aide, but because of having preschool age children at home until recent years she has been unable to use her training to produce income.

When the Smiths, who lived in a run-down, 5-room apartment, were first approached by a worker from the Mount Carmel Guild with the possibility of owning their own home, their reaction was difficult to describe. "They were indifferent. They seemed completely disinterested," the worker wrote in his report. "As I sat there explaining the manner in which home ownership could become a reality for them, Mrs. Smith was politely nodding her head but clearly not comprehending what I was saying; Mr. Smith's attention was drawn to a baseball game on television."

After a few visits, the worker realized that their lack of enthusiasm was not so much a lack of interest as it was a lack of ever considering the possibility of owning a home. The idea had never occurred to them. Their parents didn't own a home, nor did their grandparents, nor did any of their friends. And this was the manner in which the Home Ownership Program of the Mount Carmel Guild, Department of Community Living and Housing began, 3 short years ago. The Mount Carmel Guild is sponsored by the Roman Catholic Archdiocese of Newark, operating as a nonsectarian, comprehensive community service agency.

Orientation to Home Ownership

Smith, of course, is the traditional fictitious reference. But their description in this article is real in that it represents not only the 47 families which Mount Carmel has helped to purchase homes, but they and the conditions under which they lived represent the thousands of poor families who have been trapped for generations in the cycles of poverty, prejudice, and ignorance throughout our nation.

When Mount Carmel began its home ownership program for low income families, one of the problems it did not anticipate was the need to convince these people that ownership was a real possibility. Yet, this was the case. In almost every situation the initial interview was parallel to that of the Smith family. After a few sessions, families began to think that maybe it would be worth looking into, so they began coming to home owners counseling meetings conducted by Mount Car-

Mr. Mulvihill is director of public relations, Mount Carmel Guild.

mel staff members. There still were many reservations, however, and it got worse before it got better.

While workers were convincing these families of the program's feasibility, they also were explaining the many details which had to be worked out before a family could begin looking for an appropriate house. Credit difficulties had to be cleared up and safeguards initiated to prevent future credit problems; the families had to attend counseling programs in budgeting, what to look for in a house, and the responsibilities of owning a house. In short, for the program to work, a total family orientation into the world of home ownership had to take place.

Federal and State Programs Combined

Mount Carmel Guild's Home Ownership Program was developed in its Department of Community Living and Housing by combining two existing governmental housing programs. The first was *Project 75* which was funded by the New Jersey State Department of Community Affairs and administered by Mount Carmel Guild. It provided for the upgrading of housing for 75 Newark families displaced by the construction of the New Jersey College of Medicine and Dentistry. One of the provisions was a $2,000 allotment per family, to be used over a 3-year period as rent supplements so that the families would be able to live in quality housing, located in better neighborhoods than those they had vacated. The other Government program was *Sec. 235 of the Omnibus Housing Act,* passed by the U.S. Congress in 1968. It provides for low income families to receive a mortgage supplement.

Anyone who has gone through the process of purchasing a home knows that there is a sizable financial consideration before he can even begin to think about a monthly mortgage payment. These are known as closing costs and include attorneys' fees; search charges; title insurance; fire insurance; property tax escrow, usually 3 months; costs of credit check, in addition to a down payment. These prepayable charges can amount to upwards of $1,000.

The Guild requested permission from the New Jersey Department of Community Affairs to utilize the $2,000 grant (originally earmarked as rent supplement under Project 75) to cover down payment and closing costs. If this were possible, Guild representatives explained that many of the families originally to be helped by this program in finding rented housing could qualify for home ownership mortgage supplements under Sec. 235 of the Federal statute. The Guild agreed to provide, through its staff, social service counseling in addition to the services of a real estate consultant. State officials agreed to the plan and Mount Carmel set its program in motion.

For families like the Smiths to qualify under Sec. 235, they had to meet the provisions of the Federal Housing Administration's formulas for determining eligibility. Guidelines were also established by the FHA regarding the maximum amount of money which could be paid for a home, generally ranging between $22,000 and $26,000, depending upon family size. Houses being considered for purchase are subject to all FHA regulations as to their physical condition and the terms of the buyer-seller contract.

Mount Carmel Cited by HUD

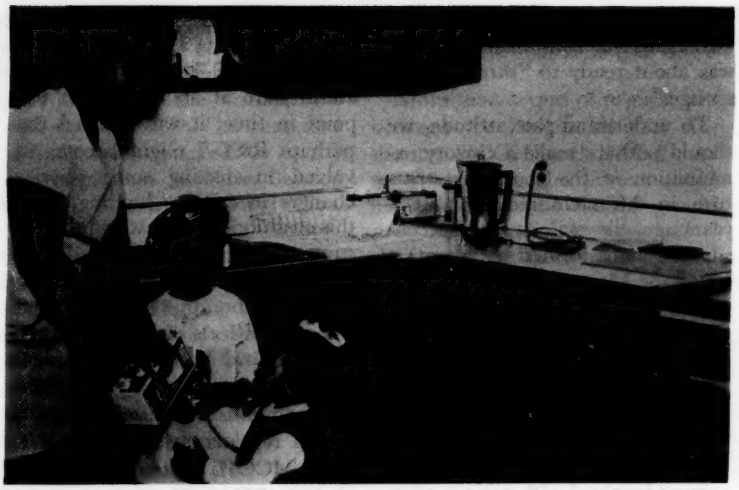
Because of the Guild's thoroughness in the selection of a house and preparation of families for home ownership, there have been no rejections of its proposals to date by FHA officials. In October 1971, the director of HUD's New York regional office, representing Secretary George Romney, conferred a citation on the Mount Carmel Guild for outstanding achievement in voluntary action in housing programs. Because of its record of quality performance in this field, Mount Carmel Guild receives the major portion of referrals for home ownership counseling from the FHA office for New Jersey.

Thirty-three Guild families have been in their homes for 1½ to 3 years; the remaining families were placed within the last year. Each family is visited frequently by a Guild worker who is also available day or night for a consultation on any major problems. Because of this personal attention to the individual needs of each family, especially in the followup activity after they have purchased a house, Mount Carmel Guild is proud of the fact that in the 3 years of operation of the Home Ownership/Social Service Program there has not been one mortgage default. In 1971 the Guild learned from a representative of the Mortgage Bankers Association of the United States that the national rate of default of mortgages among all homeowners (low, middle, and upper income) is 33 percent.

More Than Just a Housing Service

In addition to Community Living and Housing, the Guild has six other major divisions of community service: a comprehensive community mental health center; a hearing and speech diagnostic and treatment center; services for the blind and visually handicapped; psychological testing and special education for neurologically impaired, retarded, and emotionally disturbed children; narcotics rehabilitation; and a rehabilitation center for a broad variety of disabled and disadvantaged persons.

Mount Carmel Guild has over 40 years of experience in serving communities of northern New Jersey. Because of the many different services and programs offered within



Children enjoying refreshments in their new kitchen.

the Guild, coupled with its ability to reach out into the community for other services which families in the Home Ownership Program may require, it can be said that the Guild is more than just a vehicle through which low income families may receive assistance to purchase a house.

While decent housing is a prime need among low income and poor families, it is not the only critical need. The need for adequate health care, remedial and supplementary education programs, and upgrading of employment usually accompany a need for better housing. This is the reason why Mount Carmel became involved in housing and why its home ownership program has been so successful, i.e., its ability to provide the additional services either directly or through other agencies.

Using the Smith family as an example again, two of their children are twins. When the Guild had first contacted the Smiths, the twins were rapidly approaching school age but had not developed speech. Through its services in this department, Mount Carmel was able to determine that the children did not have a hearing loss as suspected. Further tests revealed a neurological impairment. The twins are now enrolled in a special education program at the Guild and are progressing reasonably well.

It cannot be said exactly what would have happened with the children had the Guild not been involved with the family through its housing program. But previous experience reveals that it can be said with reasonable certainty that these children would probably still be at home and their parents would probably still be wondering what was wrong.

With help from the older children in taking care of the younger ones, Mount Carmel was also able to locate Mrs. Smith in a job as a nurse's aide, which increased the family income, further securing the Smiths' financial position.

A New Meaning For Sacrifice

Mount Carmel has aided and educated these families in regard to their budgeting so that they may meet their monthly expenses. The families have been helped to recognize the fact that each monthly payment means further equity for them. The ideal of sacrifice is instilled in the family's motivation so that they may see that the future must be planned in the present.

Sacrifice comes as nothing new to the poor. But this program has placed a new value on sacrifice for the families involved. It has demonstrated that sacrifice need not be a negative deprivation but can be a meaningful positive step in their struggle for a better life.

Ownership of these houses represents the opportunity for growth and development which many Americans take for granted. The houses mean a roof that isn't going to leak on the baby's crib; they mean two children sharing a bedroom rather than four or five; they mean space where the older children can do their homework with good lighting, set apart from the activities of the rest of the family; and they mean a back yard where the whole family can recreate in nice weather. Since they are located in better neighorhoods, these houses mean better schools, access to better health facilities and shopping areas. Some of the families have been helped to come off full or supplementary welfare assistance or to upgrade their current employment through job training. The benefits of this program are as many as the families who have been served.

While the number of families who have purchased houses has not quite reached 50 in its more than 3 years of operation, it is only limited by available funds and manpower to process each case.

Msgr. Joseph A. Dooling, Director of the Mount Carmel Guild, last year expressed the Guild's feeling about this program in a letter to Secretary George Romney, as follows: "We feel very strongly that the home ownership concept, where possible, should be one of the primary approaches to solving the housing crisis among poor people. When combined with social services that help to upgrade family living, the responsibilities of home ownership, we are convinced, provide *an unprecedented atmosphere of hope and opportunity which these families have never known.*" ■

Accessible Housing For Boston's Disabled

HAROLD S. REMMES

For many years now, consumers in Boston have been charging that most of the agencies serving them have simply been going through the motions in a contrived impression of concern. Various committees and task forces have been formed, endless numbers of meetings have taken place, and generations of papers and reports have been produced. Although this produces high-geared activity, we have often felt that the activity's results were on a treadmill—generated by one committee to activate another committee, to study the first committee's findings which recommends that their findings "need more study" by yet another committee. This process has "revolved" to the point where the leadership of consumer activities was about ready to "throw in the sponge."

To understand this attitude, we should perhaps make a cursory examination of the consumer structure in Massachusetts.[1] About 4 years ago, the majority of the consumer groups formed a federation called the Massachusetts Council of Organizations of the Handicapped (MCOH). Each organization, large and small, was allowed one voting member and the assignment of two additional delegates to its monthly meetings. MCOH's policy is to work within the existing structure by becoming involved with various agencies, legislative bodies, committees, and commissions.

Under this organizational structure, "the Council," as it is called, was successful in numerous instances in its deliberations with various agencies and it brought about many changes. Too many times, however, the consumers had felt that some of the agencies had worked with them in a token gesture as a contrived expression of concern.

When Glen E. Gresham, M.D., assumed the position of project director at the Tufts-New England School of Medicine Research and Training Center (R&T–7) in Boston, he immediately set out to overcome some of the mistrust which had been developing between the agencies and the "consumers." Fortunately, MCOH was an appropriate, single source where consumers with diverse disabilities could be polled. Within a few weeks of his arrival, Dr. Gresham was immersed in exploring consumer needs.

Top priority on the consumer's list of "things to be done" was the provision for accessible housing for persons with mobility problems. One member group, the Massachusetts Association of Paraplegics, had been attempting to create a housing facility for its membership, but had encountered many roadblocks in its attempts to deal with the Department of Housing and Urban Development (HUD). Since these negotiations were at an impasse at that point in time, it was decided that perhaps R&T–7 might become involved in making some physical changes in existing housing. From this coalition of interest and demonstration of need the groups devised the project that became known as "The Collaborative Study to Determine the Effects of the Removal of Architectural Barriers of Residents of Low Income Housing."

A committee was formed consisting of representatives from HUD, SRS, MCOH, Boston Housing Authority (BHA), the Department of Public Welfare, the Massachusetts

Mr. Remmes is President, Massachusetts Council of Organizations of the Handicapped, Inc.

California Realtors For the Retarded

The California Real Estate Association has adopted a resolution supporting community housing for the mentally retarded. The resolution reads in part:

"The California Real Estate Association urges any real estate licensee involved in the sale of houses of real property to be used for home care services for mentally retarded persons, when alleged discrimination exists, to assist in overcoming this alleged discrimination by providing the property owners concerned with information supplied by the National Association for Retarded Children as to the ability of the mentally retarded to be an integral part of the community."

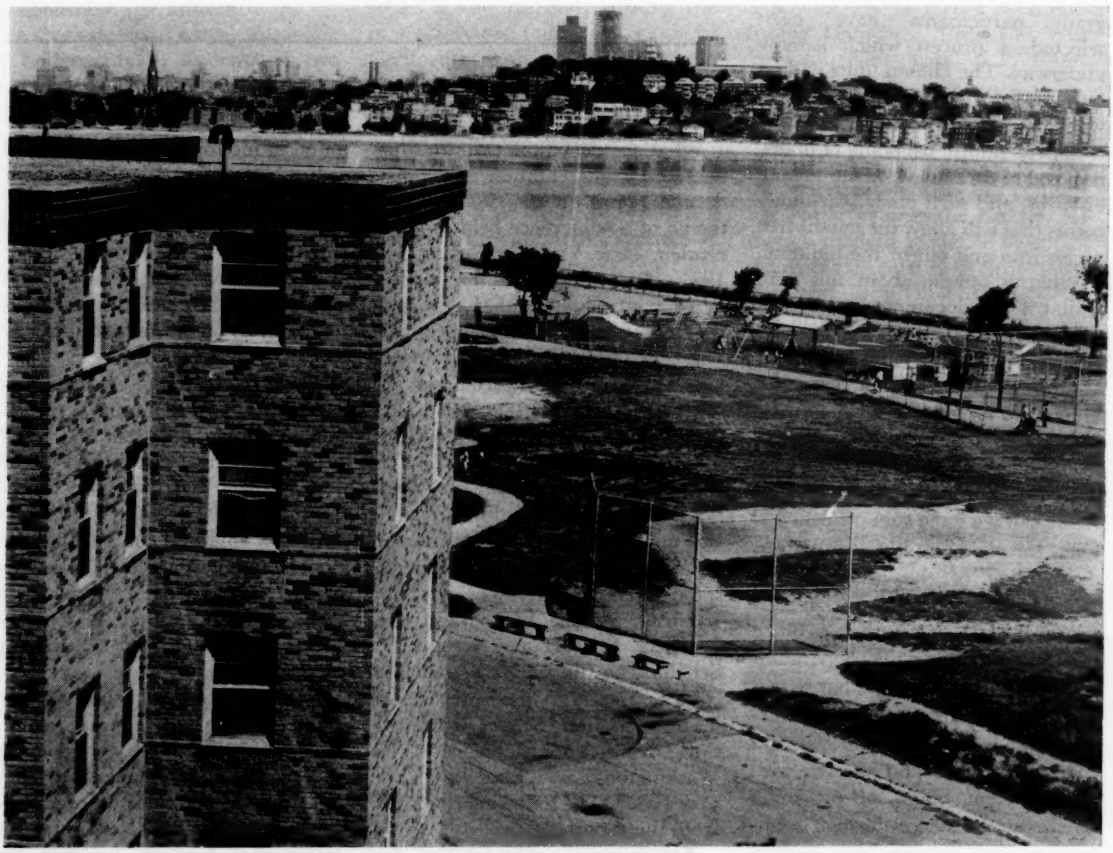
It is hoped that this campaign of education will be successfully carried to the National Association of Real Estate Boards.

Rehabilitation Commission, and other appropriate agencies. The protocol and conceptualization was, however, largely the work of the consumers and Dr. Gresham and his staff, supplemented by many good suggestions from Dr. Bernice A. Clark of the SRS regional office.

Essentially, the project has three major components: (1) the identification of persons living in facilities of the Boston Housing Authority who have mobility or functional impairments; (2) the selection of a small number of families who will be relocated in Boston Housing Authority facilities which have been made accessible by R&T–7; and (3) the study of the life styles of the selected families before and after the removal of architectural barriers.

More than a year of negotiations between the Boston Housing Authority, MCOH, and R&T–7 was required before the project could be initiated. While R&T–7 would provide the funding for the physical changes needed and in the selected apartments would provide certain staff, many obstacles had to be overcome before the BHA could ascertain which "in kind" services it could provide. Finally, however, it was determined that the BHA would provide staff time and redecoration (painting) of the selected apartments.

Phase one of the project is now underway—the identification of persons living in facilities of BHA who have mobility problems. The outreach portion of phase one is being conducted through the mails. Some 15,000 letters have been sent out to tenants of BHA facilities. The letters are written in English and in Spanish since there is a large Spanish-speaking population in the authority. Essentially the letter asks the tenant to contact the R&T center if he or members of his family have mobility problems. We felt that using the letter approach would indicate self help motivation on the part of the tenants who did contact us.



A beautiful view means nothing if your apartment "locks you into that one view."

Upon tenant response to our letter a telephone interview is conducted as a screening device. Those who seem most appropriate for housing service are then visited in their homes. Admission is based on projected rehabilitation potential, motivation for services, need or hardship, and the availability of appropriate facilities in the area where the family would be located.

Although we will make every effort to keep people in their own neighborhoods, some relocation will be necessary. In these cases, R&T–7 will bear moving costs. When the client is a public assistance recipient, the Welfare Department will pick up the relocation tab.

Site surveys have been conducted to find the most suitable for renovation. Final selections, however, are not to be made until after the program participants have been selected, a process which is now underway. The chosen units will be redecorated (painted) and R&T–7 will make such accessibility modifications as ramps, widening of doors, removal of thresholds, or the cutting of curbs, and such other rearrangements that will allow the tenant free access into and out of the building.

What is unique about this plan is that it will document for the first time a rationale for allowing the local housing authorities to request additional funds in their operating budgets to service the needs of their handicapped tenants (for changes in physical plant). Although the project is still in its infancy, we already can see some spin-off benefits. One, for example, is a greater understanding of the needs of the handicapped population by key staff within the Housing Authority. Since the project requires the cooperation of several departments, it has served to move the authority one step further away from the "bricks and mortar" tradition and into line with their current policy of providing ameliorated services through cooperation with outside local service providers.

Another unique feature is that the organized consumer groups have had input from the conceptualization to the fruition of the project, and their expertise will be utilized through the completion of the work. Further, the involvement of a broadly representative group within the advisory board will bring to the participants in the project (and even those who respond to the initial screening, but are deemed inappropriate for the study) referral to an appropriate agency for services other than housing needs.

It would be premature to state that the anticipated positive results of the study will be achieved. It can be said, however, that this project has resulted in the establishment of a harmonious working relationship for both professionals and consumers alike and has brought the consumers one giant step closer toward acceptance as responsible and willing partners who the agencies need not feel represent a threat to their existence.

Strangely enough, despite the rhetoric, meetings, and negotiations required, a number of families will be more appropriately housed and could conceivably add to the tax base, rather than be recipients of public assistance. And, as the consumers say, "that's the name of the game."

Note

(*1*) *An expanded statement on the thrust of consumerism in Massachusetts is given in "Consumer Involvement In Rehabilitation,"* Rehabilitation Record, *July–August 1972, pages 33–35.*

Transitional Housing For The Deaf

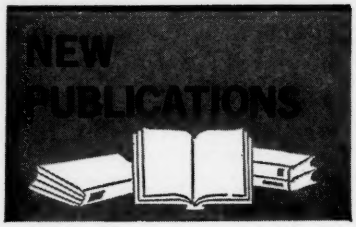
What should be the priorities for deafness rehabilitation in this decade? That question formed the theme of a conference held in Terrytown, New York, in September 1971. To quote from the monograph's introduction that reported the conference: "The meetings . . . were unfettered by prearranged agenda. No topic was precluded; no suggestion summarily dismissed. The result . . . encompasses the major issues in the rehabilitation of the deaf client, with some questions not previously discussed in this context now brought to the attention of those concerned with the welfare of the deaf community."

Editors of the monograph are Larry G. Stewart and Jerome D. Schein. The full report is available from: Deafness Research and Training Center, School of Education, New York University, 80 Washington Square East, New York City 10003. The following is quoted from the report.

Employment opportunities for deaf people are most often to be found in metropoltian areas, and as a result most deaf people must relocate and live away from their families. This need to live independently imposes many adjustment problems on young deaf people, and creates especially stressful problems for severely handicapped or low achieving deaf people.

There is a need for special housing facilities within the larger metropolitan areas for assisting deaf people who have just moved to the area and who lack the ability to live by themselves while adjusting to their new environment. Such transitional facilities need staff members who can provide assistance to facility residents as they seek permanent housing and learn to function independently.

[We recommend] that appropriate Federal and State health, education, and welfare agencies recognize this need and help to meet it by providing funds to organizations and agencies to establish transitional housing facilities for deaf people. ■



Bridges and Ladders: A Descriptive Study In New Careers, Working Paper #2, 1971. Case Western Reserve University, Rehabilitation Careers Project, 11027 Magnolia Dr., Cleveland, Ohio 44106. 51 pages.

Will the socially disadvantaged evidence an interest in rehabilitation careers in the context of their career options, mobility hopes, and willingness to serve as agency-community links? This study seeks to determine the answer.

A cross-sectional survey was made of undergraduate students at two midwestern schools which have specific New Careers training programs (programs designed to meet the needs of the poor and disadvantaged), as well as a large number of students who are poor, blue-collar workers, or recruited from the inner city ghetto areas. There are comparisons made among individuals in actual New Careers training programs, potential New Careerists—those considered good candidates for New Careers jobs in the future—and students from similar backgrounds as the above categories but who are neither in New Careers training programs nor seem to be aspiring to New Careers jobs.

In a Nutshell: A guide for Stroke Rehabilitation in the Community Hospital. National Easter Seal Society for Crippled Children and Adults, 2032 West Ogden Ave., Chicago, Ill. 60612. 24 pages. 30 cents.

Certain specific guidelines which would enable hospitals to provide better rehabilitation care for stroke victims are described in this new publication. Community hospitals are shown how to organize an effective stroke service which would take into positive consideration all the psychological and social implications of a stroke disability, and which would also give a more sensitive awareness of the patient's needs and capabilities. By following the practical suggestions of method and approach, community medical centers can make the most of their available resources in order that they may help the stroke patient recover in the best way possible.

Directory of Services for Visually Handicapped in Southern California. American Association of Workers for the Blind, Inc. Special Education Department, California State College, Los Angeles, Calif. 90032. 42 pages. $1.

The American Association of Workers for the Blind, Inc. has published a new directory listing the many services found in Southern California which are offered to blind and visually handicapped persons. This publication provides a thoroughly inclusive, up-to-date, handy reference for people in this region who work with the blind.

Contract Procurement Practices of Sheltered Workshops. Michael M. Dolnick. National Society for Crippled Children and Adults, Inc. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 98 pages. $1.

Following its original publication in 1963 as a rehabilitation research project of the National Society for Crippled Children and Adults, Inc., this study received a great deal of notice and was ultimately accepted as the standard reference work in the area of contract procurement for sheltered workshops.

Due to an ever increasing demand and need, the report now appears in its third printing. The reissuance is the result of several related circumstances which include: the wide expansion and development of sheltered workshop training programs under RSA sponsorship, recent amendments to the Wagner-O'Day Act which will greatly increase the volume of government purchases from sheltered workshops, and an urging by the Federal Wage and Hour Administration for sheltered workshops to follow the manual's outline of procedures on pricing and bidding.

The information and reference data presented by this conclusive study include: methods and techniques used by individual sheltered workshops in procuring contracts, various "how-to-do-it" sections designed to help beginning and less experienced workshops, and established principles and detailed conclusions whose relevance and guidance have not apparently diminished since the time of the first printing.

Friends, Not Outcasts: Social Rehabilitation of Leprosy Patients. I. K. Gill, Ph. D. Helios Book Publishing Company, Inc., 150 West 28th St., New York, N.Y. 10001. 144 pages. $4.50.

A sensitive study of social work among victims of leprosy, this book examines the importance of non-medical treatment in the continuing battle against the disease. Although modern medicine has made many advancements in early detection and in finding drugs which will arrest the disease, there is still a great deal to accomplish in the social and psychological rehabilitation of leprosy victims. This publication demonstrates what steps should and have been taken in this area, in order to help the patients help themselves.

The book emphasizes the immediate need for an international program to inform the public of the modern facts about Hansen's disease in order to help stamp out general misconceptions and prejudice. In this sense the publication is presented not only as an educational manual for social workers, but also as a humanitarian guide to some of the complex challenges offered by the social rehabilitation of leprosy patients.

Six Giants of Rehabilitation

Dorothy Rigdon

New Life for Millions. Russell J. N. Dean. Hastings House, 1972. 180 pages. $6.95.

When I was named editor of the newly launched *Rehabilitation Record* in 1961, I came to the job in sublime ignorance of the "beat." It seems impossible now but I remember that I first heard the word "prosthesis" while in a conversation with the late Ollie Kincannon, and I believed him when he solemnly told me that word had something to do with the oldest profession.

I needed a lot of education then, and I needed it fast in order to avoid the kinds of blunders that could have crippled a new professional magazine just when it needed to establish a measure of credibility. So I talked to everybody who knew about rehabilitation, and I asked questions copiously. As I learned a few facts, I needed to dig deeper. By that time, I had discovered one of the real treasure houses of rehabilitation information—Russell J. N. Dean, then an assistant commissioner to Mary E. Switzer in the Office of Vocational Rehabilitation.

I used to marvel at Russ Dean. I would ask him a question or else say something that revealed my total lack of background. And Russ would relate to me, with never a falter, all that I needed to know at the moment of the ins and outs of the rehabilitation topic under discussion.

One day, for example, he explained in such a clear way that I really understood it for the first time, the significance of a new piece of legislation that had just been signed by the President. At last I knew who had proposed what part of the new bill to fill what need, who supported the provisions and how effective that support was, and which legislators had what effect on the final provisions.

By the time I had been on the staff for a few years, I was so accustomed to asking Mr. Dean the tough questions and getting the smooth and accurate answers that I ceased to wonder how on earth he could know so much and remember so readily what he knew. I just took that for granted.

But now, as I read Mr. Dean's new book, *New Life for Millions,* I am impressed all over again. It is quite a feat to produce such a chronicle in such detail and to fit all the pieces together so neatly. He did, I am sure, do research for this volume, but it sounds as if he has written largely from his own knowledge. The reader could believe that he operated like Sir Kenneth Clark, who was asked what kind of literary research he did in preparation for writing the great book, *Civilisation.* "None," he replied. "I just sat down and began to write."

The history of the rehabilitation movement is in much better shape because Russ Dean sat down and began to write. It is especially fortunate that he did since, for a program that is something like 70 years old, rehabilitation has a scant written history. The Dean book goes quite a way toward remedying that shortcoming.

New Life for Millions follows the author's belief, expressed in the preface, that "The important things in life do not get done by programs or laws or organizations. They get done by people." This book relates the story of rehabilitation in general—not just of one program or segment—by tying its accomplishments to six giants of the movement. They are, in the order of their appearance in the book, which is approximately also the order of their appearance on the official scene: Jeremiah Milbank, John A. Kratz, Dr. Henry H. Kessler, Dr. Frank H. Krusen, Dr. Howard A. Rusk, and Miss Mary E. Switzer.

Why those particular six, why not seven or eight, or why not one or more different people? Well that is, as we say, the speaker's choice. Mr. Dean chose those six, and he has told an interesting story of how each worked in a different sphere to give a powerful forward movement to programs that benefit handicapped people. All six, in fact, have devoted their lives to the improvement of conditions for the disabled.

All of the major developments recorded in this book are described in the context of the U.S. or world events that influenced them. This gives *New Life for Millions* a special quality that adds to the story's interest.

There are lots of other people in this book besides the six major characters. In fact, the book's index almost amounts to a litany of those who have contributed signally to rehabilitation. It begins with Abramson, Dr. Arthur H., 1955 Handicapped American of the Year, physician, paraplegic, and rehabilitation leader. And it ends, alphabetically speaking with Zeiter, Dr. Walter J., one of the trio—with Dr. John S. Coulter and Dr. Frank H. Krusen—who won the first certificates of specialization from the American Board of Physical Medicine and Rehabilitation soon after its formation in 1947.

Because Russell Dean was involved in one or another official role with most of the incidents he records in this book, there is a spe-

(Continued on page 37.)

Miss Rigdon, formerly editor of the Rehabilitation Record, *is now a freelance editorial consultant.*

Wheelchairs With Pizazz

America's millions of wheelchair occupants are being invited to escape the psychological barriers of their "cage of chrome" by way of artistic and ingenious wheelchair decorators, through a contest which will run from November 20, 1972 to March 20, 1973. Wheelchair Decor is being supported by a public service grant from Mutual of N.Y.

"The wheelchair is the handicapped person's most constant companion. The objective of the competition is to make it a friend instead of an enemy. This new look for wheelchairs can display color, style, and fashion—the fashioned look instead of the antiseptic look," says Rex Taylor, creator and director of Wheelchair Decor.

The seed for this public service program for the handicapped was planted some years ago when Mr. Taylor's wife, Susan, of Greenwich, Connecticut, an active woman in her early forties, was struck with multiple sclerosis. To her, the wheelchair became a symbol that robbed her of individuality.

Susan's family came up with a simple idea that helped her regain her confidence. Small artistic touches were added to the wheelchair. Flashes of color to match her dress. Colorful backrest designs to match the seasons and occasions. Both wheelchair and owner took on a new personality. As Susan tells it, "I'd give anything in the world to walk away from this chair, but it doesn't feel like a prison anymore. Somehow my whole attitude toward my chair has changed. I'm still stuck with it, but if I must be in a wheelchair, it's nice to be in a cheerful, colorful one."

Mr. Taylor initially structured this exciting project in conjunction with the President's Committee on Employment of the Handicapped, which is celebrating its 25th anniversary. The Wheelchair Decor competition also has the enthusiastic support of the National Easter Seal Society for Crippled Children and Adults, the National Multiple Sclerosis Societies, the Muscular Dystrophy Associations, United Cerebral Palsy Association, American Nursing Home Association, and other health organizations which have joined together in support of this public service program.

Individual opinion leaders in the health field have expressed delight with the psychological lift that Wheelchair Decor can bring to the disabled. One such person is Dr. Howard Rusk, Director, Institute of Rehabilitation Medicine of New York. He said: "This is a most imaginative program that I think will bring interest and color into the lives of many disabled people who are confined to a wheelchair whether they are in nursing homes, institutions or out in the community."

The program itself is simple and straightforward. Entrants—wheelchair occupants—will submit original designs that have been executed on their wheelchairs, either by themselves or by friends or relatives, by way of color photographs. Backrests, skirt guards, and arm rests can be decorated with any kind of suitable material such as fabrics, decals, colored tape, or other materials.

The program encompasses all income brackets since the cost for creating a wheelchair outfit is minimal and the areas for developing

Mr. George Bunyan, a stroke victim, and nurse at Courtland Gardens Nursing Home, talk tulips.

COVER PHOTO: Mrs. Rex Taylor, whose children conceived decor idea, poses with another famous wheelchair occupant, Raymond Burr.

unusual and exciting designs are unlimited. Entries will be judged on the basis of taste and imagination which best expresses the individual personality.

Competitors will be judged in four age categories: from 4 to 12 years old; 13 to 21 years old; 22 to 55 years old; and over 55 years old. These age differentials should, accordingly, reflect the different styles and interests of these age groups.

Contestants will be solicited from rehabilitation centers, nursing and convalescent homes, hospitals, and other sources. A widespread publicity campaign will be mounted to encourage entries from wheelchair individuals in their own homes.

Victor Keppler, the Dean of American Photography, will head a panel of judges which includes artist Stevan Dohanos, designer George Giusti, and two fashion experts.

Prizes

A champion will be chosen from each age category. First prize for each champion will be $500 in cash. In addition, the champions will be invited to attend a special presentation ceremony in Washington, D.C., at the annual meeting of the President's Committee. Date is May 5, 1973. All expenses for the trip will be paid.

Second prize in each category will be $250, and the third prize will be $150. Many additional prizes, consisting of merchandise suited for use by the physically handicapped, will be awarded in each category.

How To Enter

1. After you decorate your wheelchair, send at least one but not more than three photographs.

2. *All photographs must be color prints.* They may be any size up to 5 x 7.

3. Photograph must show competitor seated in the wheelchair.

4. Good, sharp photographs will obviously show off your design to its best advantage. However, this is *not* a photography contest.

5. The purpose of the photographs is to give the judges a clear idea of the imagination and individuality of your decor.

6. It is suggested that you enter one overall photograph of the decorated wheelchair which shows it in its entirety. You may send two additional photographs that show important details of your decor.

If a decor entry blank is not available to you, attach your color photographs to a piece of paper which includes the following information: name, age, address (include nursing home or institution address, if pertinent), city, State, zip code, nature of disability, time you have been wheelchair-bound.

Be sure to identify each of your photographs on the back with you name and address. Wrap your photographs carefully to protect them in mailing. Mail them to: Wheelchair Decor, P.O. Box 328, Westport, Connecticut 06880.

Contest Dates

Entries may be mailed any time beginning November 20, 1972. All entries must be postmarked no later than midnight, March 20, 1973.

It is important that entrants save the design shown in their photographs. Champions will be required to wear their prize-winning designs at the Washington, D.C. ceremonies. No substitute decor will be allowed. ■

Sharon Kay Ritchie, Miss America in 1956 and now a volunteer at the Stanford Easter Seal Rehabilitation Center, deliberates with Mike Murphy on what new, attractive decor will grace his chair.

As presently used, it is little more than "radio with a few pictures."

teleVISION

JEROME SCHEIN, PH.D., THOMAS FREEBAIRN, BERTRAM SUND, SUSAN HOOKER

Almost all of the modern electronic media—telephone, motion pictures, radio—have been communication disasters for the deaf. But television holds a promise . . .

Progress in media development has seldom been beneficial for deaf people. The telephone, ironically enough, put them at a great disadvantage, rather than "aiding the development of speech for the deaf" as Alexander Graham Bell intended. Motion pictures were different. They were ideal for deaf audiences—until they changed from silents to talkies. Of course, radio was a communication disaster for deaf persons. *Then came television.*

TV opened mass communication again to the deaf community. But it did not remain teleVISION very long. As presently used, it is little more than "radio with a few pictures." There is heavy dependence on dialogue to forward the story. News broadcasts, in particular, are mostly read. Frequently the speaker cannot be seen or his face is too tiny an image to make lipreading effective. As developed, TV has not achieved its potential as a communications medium for deaf people.

For each of the media, except radio, deaf people recently have succeeded in promoting adjuncts which permit their use without the audio dependence. The phonetype connected to the teletypewriter makes the telephone available to deaf users. Captioned Films for the deaf has restored motion pictures to deaf users. Now similar possibilities are opening in television.

There are no theoretical or technical reasons for the exclusion of deaf persons from TV as both an information and an entertainment source. Forty-seven TV stations have had or are now showing regularly scheduled programs prepared with deaf viewers in mind. There are 18 daily news programs, 15 emergency warning services, 15 weekly information and entertainment series.

In addition to these regularly scheduled features there are occasional programs and brief, nationally distributed series, like NBC's "Quiet Language For A Noisy World" and "Say it With Hands." Also NBC has initiated a new, daily half hour show for preschool children, "Watch Your Child/The Me-Too Show." Scheduled in 27 major markets, the show features a young deaf girl who simulatenously translates dialogue into the language of signs. Taken together, these programs illustrate a rapidly growing desire on the part of the industry to serve deaf and hearing impaired audiences.

Captioning General Audience Programs

Captions have appeared occasionally on TV programs for years. For example, batting averages have been shown while the hitter stands at the plate. No technical problem in transmitting this kind of visual information exists. Why then are

Dr. Schein is Director, Deafness Research and Training Center, New York University School of Education and Susan Hooker is Assistant to the Director. Mr. Freebairn is Television Consultant and Mr. Sund is Television Coordinator at the Training Center.

captions not provided regularly to deaf viewers on all programs?

The answer to the question lies in the fact that broadcasters fear that captions will be objectionable to hearing viewers (even though there is very little research to support this assumption) and writing captions is difficult and involves added expense.

Optional reception of captions. If captions could be received at the viewer's discretion, the first objection would be baseless.

A technically and economically feasible method for optional captioning has been developed by the National Bureau of Standards (NBS). The captions are broadcast in an electronic code which appears only on television screens equipped with an adaptor. When the adaptor is in the "on" position, the captions are visible. Otherwise, they cannot be seen.

This system, originally developed by NBS to disseminate accurate time information, codes a tiny portion of the signal that broadcasters normally use to transmit alphanumeric information, such as time of day, channel identification, and special test messages. This portion of the video signal is called the "vertical trace interval."

It has been estimated that a simple, low-cost decoding module could be mass produced and installed in TV sets at the factory. Local television stations would purchase relatively inexpensive equipment to transmit captions along with their regular broadcasts. For network originations, the encoded captions would be transmitted with the program. There remain only a few small engineering and design problems to make this system marketable.

To date no filings with the Federal Communications Commission (FCC) have been made for multiple usage of the vertical trace interval. The FCC has adopted the general principle that the vertical trace interval may be used for transmission of additional data supplementary to the basic video signal. Such vertical interval signals are usually invisible on the home television receiver. It is now quite common for test signals to be transmitted via the vertical trace interval. A favorable ruling on the NBS system by the Commission would open the way for television captions, since its authorization to include captioning within the vertical trace interval is required by law.

In short, then, there is no theoretical reason why captions cannot presently accompany every broadcast. There are only minor engineering problems remaining in making the reception of captions optional. Nor is the cost of the necessary equipment anticipated to be high, either to the broadcasters or the set owners. Thus, few barriers remain before realization of the capability for the transmission and optional reception of captions on a mass basis.

Writing and producing captions. The writing and producing of captions presents problems similar to those faced by the Captioned Films branch of the U.S. Office of Education in captioning entertainment and educational films for deaf viewers. Generally, a person's speaking rate is faster than his reading rate; therefore, a simple word-for-word presentation of the TV script would seldom be used. Deaf people do not need, and probably would not want, a literal transmission of the dialogue accompanying the pictures on their screens.*

Further considerations, such as the recognition of the vocabulary levels of deaf persons, also should be taken into account. Several studies have estimated that the average deaf adult reads below a fourth-grade level. Standards for TV captions must be developed along with production techniques for broadcast. Minor technical details remain, such as placement and size of captions.

Most importantly, broadcasters must be provided some incentives (or subsidies) to produce captions. Writing captions is an art. To do a satisfactory translation of a script involves expense. However, many shows are unscripted or only partially scripted. Captioning such programs would be costly, unless engineering research could yield some new devices to reduce labor costs.

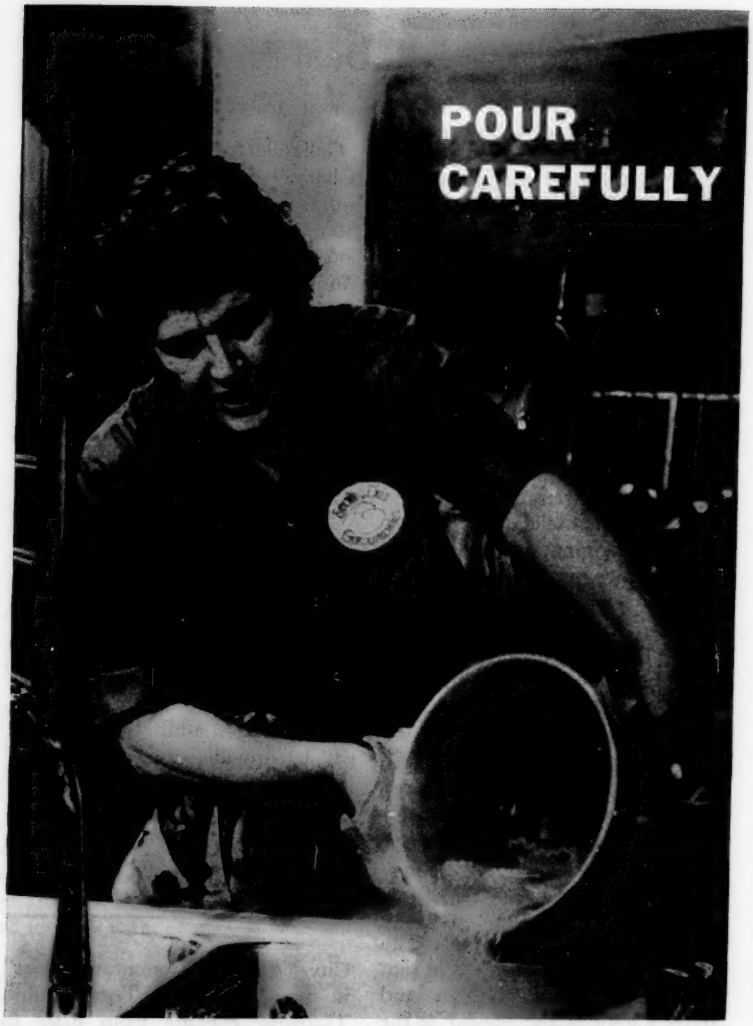
In any event, having the capability to transmit optionally viewed captions is not enough to assure deaf audiences that captions will be frequently available. Ways to meet or reduce the costs of captioning must be found. Or broadcasters must be encouraged to bear the added costs. Nobody should be discouraged about the possibilities of finding a satisfactory, long term solution to this half of the captioning coin.

Special Programing For Deaf Audiences

Growing opportunities now exist for broadcasting original materials designed especially for deaf audiences. The increasing appearance of such programs accurately reflects the current interest of commercial broadcasters in offering programs for deaf people.

Deaf people not only want access to regular broadcasts, they also want programs on subjects unlikely to be covered by general-audience TV. No network has ever sent, or is likely to send, a crew to cover the International Games for the Deaf ("the deaf Olympics"). News broadcasters will probably ignore the reports from the forthcoming biennial convention of the National Association of the Deaf. Such events have a narrow range of

*The availability of optional captions would benefit not only deaf people, but also ethnic groups desiring training in English as a second language and children needing supplementary reading practice. However, if captions are also to help hearing children and adults learn to read, word-for-word captions would seem to be necessary.



Julia Child makes lasagne à la Français on "The French Chef."

interest. For deaf audiences to find on their screens events of interest to themselves, as well as produced in a manner they can comprehend, some special arrangements must be made.

Obtaining transmission time for special programs. Every station, whether commercial or educational, cable or over-the-air, has some free air time. Deaf viewers have a legitimate claim to a portion of the public-service broadcasting time required by the FCC. Clearly, programs produced specifically for deaf viewers qualify as a public service.

In December 1970, the FCC issued a public notice to all over-the-air television stations, urging them to include visual aids in their telecasts for the benefit of deaf viewers. The Commission anticipates eventually mandating visual assists in emergency situations.

FCC rules now stipulate that all new cable systems built in the top 100 markets (which includes over 85 percent of the population) must provide channels for governmental, educational, and public use. Special programing for deaf audiences can be carried on these public-access channels. In addition, many cable operators have chosen to reserve a separate channel for their own commercial use, another potential outlet for programing for deaf persons.

The experiences of those who are now broadcasting programs for deaf audiences show that securing air time is not a very serious problem. Those who have broadcast-quality tapes or films have generally been able to find a station willing to transmit their materials, either on the cable or over the air.

Producing special programs. A more serious problem is producing the programing to be broadcast. Television specifically for deaf audiences falls into three general categories: news (including emergency notifications and weather information), education or public affairs, and entertainment programing. There is a variety of possible formats for each of the program types. An investigation of deaf audiences' desires as to type and format of programs needs to be conducted.

The principal stumbling block to producing for deaf audiences is money. Television production costs are high; broadcast-quality production facilities are almost prohibitively expensive for occasional use. The typical black-and-white, half-hour tape for use by network television costs from $10,000 to $50,000 to produce. Color doubles the price.

Economical, perhaps nominally profitable, methods of production and distribution must be developed outside or alongside commercial TV if original programing for deaf persons is to be facilitated on a large scale. So far broadcasters have seen only marginal self-interest in the encouragement of original television programing for the deaf community—primarily because of an apparent lack of financial benefits within the present marketing and distribution systems.

The creation of a cooperative syndicate of production facilities would be particularly useful. It is fundamental to the development of original programing for deaf persons. Experience shows that few sponsors, whether commercial, governmental, or private, are willing to support the production of materials for exclusive telecast in a single, limited broadcast area. And because the alternative of a broad, effective distribution network has never been established, very little original programing, other than local news shows, has been attempted.

The concept of a national television cooperative for deaf viewers is simple. For instance, if there were 100 agencies in the network, each willing to produce just one program, then by simple scheduling, each member station would receive for its own broadcast use a series of 100 programs. Production costs are reduced in proportion to the number of participants. Such economies of scale permit a considerable increase in programing, and they would encourage funding for experimentation with new approaches and formats. Once established, the cooperative would be self-sustaining.

In return for producing 1 hour of special-interest programing, each cooperating member would receive many times that number of hours of public-service material. Is that a good deal? When approached with this plan, a vice president of a local television station responded, "That's one project I can approve without consulting my board!"

Some Ongoing Programing

Local origination. More than 40 stations across the U.S. have offered regular programing for deaf audiences. Approximately 20 of these stations offer news programs which are manually interpreted. For example, KRON–TV (San Francisco) has inaugurated a newscast for deaf residents in the Bay area called "Newsign." Broadcast weekday mornings within an available local segment of the "Today Show," it features national and local news plus special features for deaf viewers.

The program is produced and conducted by two young, deaf San Francisco residents who interpret the news for the more than 25,000 deaf persons within the Greater San Francisco Bay area.

Another approach to the presentation of news for deaf people is being broadcast over WXXI–TV (Rochester, New York). Signed interpretation of the ABC–TV Network's "Harry Reasoner News" is simultaneously transmitted on the local educational-television outlet.

Network origination. Earlier this year, a 10-program series, "A Quiet Language for a Noisy World," was broadcast over the NBC–TV Network. The series, created by Mrs. Ethel Untermeyer, was produced in Chicago. The programs featured discussions and demonstrations of manual communication with deaf persons. As well as entertaining deaf viewers, the series informed and educated the general viewing audience about sign language.

Over 27 NBC–TV Network stations now carry the daily program, "Watch Your Child/The Me-Too Show," which is interpreted in sign language for deaf children and adults. Captions also appear at the beginning of each new activity to explain to parents the purpose of what the children are doing. Technical assistance on the use of sign language is provided by the Deafness Research & Training Center (New York University).

The Public Broadcasting Service is now captioning 26 programs of the "French Chef" series featuring Julia Child.

CATV activity. Since September 1971, the New York University Deafness Research & Training Center has sponsored 2 hours of prime time programing per week on the public-access channel in New York City. "The Deaf Community Hour" is broadcast every Tuesday and Thursday evening from 8:00 to 9:00. Production costs have been covered by a grant from the Center for the Analysis of Public Issues (Princeton, New Jersey) because they feel the experience gained will be valuable to other special interest groups.

Reaction has been very gratifying. Both the cable franchises, Sterling Manhattan and TelePrompter, provide free time for broadcast and advertise the series. The deaf community has also responded favorably. Viewer reactions are now being gathered. An evaluation of the rehabilitation potential of specially designed television programing is also planned. ■

Deaf-Produced TV Programs

Gallaudet College and WJZ–TV (Channel 13) of Baltimore, Maryland, have been working together to produce sixty-five 28-minute television programs to be aired daily, Monday through Friday, for 13 weeks beginning this fall.

Developed to appeal to the general public as well as hearing impaired audiences, the programs will include three areas: general education courses taught by Gallaudet faculty members, a course in manual communication presented by Williard Madsen, coordinator of the college's Sign Language Program, and interviews with deaf persons.

Since the program will employ the simultaneous method of communication (signing and talking at the same time), it will be easily understood by both deaf and hearing persons. In addition, captioning will be provided for those hearing impaired persons who do not know sign language. No other television program has ever attempted such a completely unique approach. ■

. . On Transportation

I was delighted to receive my July-August issue of the *Rehabilitation Record* and find "the whole thing" devoted to transportation and architectural barriers. . . .

. . . I have spearheaded a survey of the architectural barriers in our city of Springfield and published a *Building Access Guide*. We plan to go before the city council and ask for revision of curb repair plans in our downtown area for the benefit of senior citizens and the handicapped.

I have also suggested to . . . [the] executive director of the Illinois Governor's Committee on Employment of the Handicapped that he contact the International Office of Altrusa and urge them to adopt architectural barrier surveys in all their clubs in 13 countries as a single, international project they could all identify with.

As you can see from the above, your copy of the *Rehabilitation Record* on this subject is most appropriate and timely, and I thank you for this additional help.

Eileen McCune
Chief of Public Information
Division of Vocational Rehabilitation
Springfield, Illinois

. . . Special Features

The up-to-date publication of "Project Reports" and "New Publications" in the *Rehabilitation Record* has been a great aid to us in our training efforts. In order to stay relevant professionally and provide meaningful educational programs, there must be immediate knowledge of the latest developments in the field. The *Rehabilitation Record* should be commended, for providing a meaningful training resource through its topical presentations and special features.

Charles S. Richman
Program Specialist
Region III Training Program for Facilities Personnel
University of Maryland

. . . On July Edition

I really enjoyed reading it [July–August *Rehabilitation Record*] and I feel it has a tremendous amount of very practical information that's very meaningful.

Raymond C. Cheever
Publisher & Editor
Accent on Living

. . . On Tin Can Caper

I know you will be as pleased as we are about the continuing interest generated by your publication of my story on "Florida's Tin Can Caper" at the Sunland Training Center for the Retarded at Marianna. First, of course, was the valuable original use of the article. . . . It received a lot of favorable comment. The rest:

NBC in New York City saw the *Rehabilitation Record* story, and asked that a color film be made for a network program. We sought out a professional for the assignment—an experienced filmman with the Florida State University WFSU–TV station, a PBS outlet. Accompanying him for script notes, we shot segments of the whole Center, including the Tin Canners.

In filming the documentary, WFSU–TV got interested, staged a live program of its own with HRS commentary, and made a videotape for any possible future needs. This show accumulated more favorable reaction, so we are in the process of doubling the footage to make a sound film for other types of presentations.

Clyde L. Reece
Information Specialist
Florida Department of Health and Rehabilitative Services

. . . On Wood County Project

A summary of findings developed in the research and demonstration project (RD 1629–G), *The Wood County Project: An Expanded Program of Vocational Rehabilitation,* was printed in the September–October 1970 edition of *Rehabilitation Record.* The following letter clarifies some aspects of that report. Page numbers indicated in the letter refer to pages in the final report, not to the magazine's article "Total Rehabilitation in Wood County."

March 18, 1971

To Whom It May Concern:

It has come to our attention recently that a statement made concerning public assistance expenditures in the final report of the Wood County project is in error. The project demonstrated that the culturally-handicapped members of our society can be successfully rehabilitated in a Midwestern, rural-urban area, with a predominantly Caucasian population, using traditional vocational rehabilitation services. It was incorrectly reported, however, that the total Department of Public Welfare (DPW) expenditures in Wood County were reduced by 50 percent from FY 1966 to 1967 (paragraph 1, page 265). Unfortunately for taxpayers, this was not the case.

It was not the intent of the research plan of the project to investigate the change in the Wood County DPW budget, and the statement in question was ancillary to the primary research objective. The figures concerning the reduction in the annual DPW budget were ob-

TABLE 1.—*Public Assistance Data Supplied by Wood County Department of Welfare for WCP Final Report*

Category	Fiscal year							
	1963–64		1964–65		1965–66		1966–67	
	$\bar{X}$ cases per month	Total yearly amount	$\bar{X}$ cases per month	Total yearly amount	$\bar{X}$ cases per month	Total yearly amount	$\bar{X}$ cases per month	Total yearly amount
Old age assistance	498	619, 993	487	666, 047	461	673, 503	317	176, 435
Aid to the blind	12	14, 068	11	12, 137	12	15, 695	8	6, 044
Aid to the disabled	100	127, 983	108	141, 825	105	137, 432	68	40, 673
AFDC (parents or relatives)	118	228, 941	111	232, 151	108	227, 331	116	249, 676
General assistance	115	157, 641	107	159, 928	86	136, 924	61	95, 375
Subtotal		1, 148, 626		1, 212, 088		1, 190, 885		568, 203
AFDC (foster care)	30	21, 000	37	26, 059	32	25, 293	49	42, 202
Subtotal		1, 169, 626		1, 238, 147		1, 216, 178		610, 405
Administration		135, 162		162, 979		184, 244		207, 215
Total		1, 304, 788		1, 401, 126		1, 400, 422		817, 620

Source: Wood County Department of Public Welfare records as provided by the Director, February 1968.

tained from the Director of the Wood County DPW for the purpose of examining the reduction in public assistance payments made to *vocational rehabilitation clients* (pages 265–268). Specifically, the number of cases per month (by category of assistance) and the yearly amount of assistance (again, by category) were requested. Regretfully, however, the University of Wisconsin-Regional Rehabilitation Research Institute (UW–RRRI) researchers were *not* informed of an accounting change which separated *medical assistance* from other categories of assistance beginning in 1967, whereas this had not been done previously. Since only the same categories were compared each year, the exclusion of medical assistance from the total amount gave the illusion of a dramatic decrease in the 1967 yearly figure. Herein lies the source of the erroneous statement. Table 1 is a presentation of the original data provided by the Wood County DPW Director (the primary data source); one can readily observe the logic of our interpretation, given the fact that we had no knowledge of the accounting change. There was never an intention to misrepresent the facts; we were simply not fully informed. All other data collected and reported in the final project report was either collected or monitored by the UW–RRRI research staff.

Moreover, in addition to not being informed of the accounting change, the researchers had no reason to doubt the accuracy of the data obtained from the DPW office after receipt of the following letter which had been read into and published in the *Congressional Record* (May 6, 1968):

As far as the relief load in Wood County is concerned, it has been more than cut in half since the inception of the project. Just prior to the beginning of the project, the relief load totaled 145 cases. On May 1, 1967, it totaled only 59 cases. I believe very much that considerable credit must be given to this project for the reduction and while I have not always been in agreement with the program, I would be the first to admit that an expanded rehabilitation program would ultimately prove beneficial to taxpayers.

—Wood County Welfare Director

Regardless, it has come to light that, in fact, the Wood County public assistance budget continued to *increase—not decrease*—despite the rehabilitation of 1,021 disabled and disadvantaged persons from the county (see Table 2). As described on pages 265–268 . . . an examination of the Wood County DPW case rosters revealed that 62 percent of the 453 clients rehabilitated in the 1967 fiscal year had been public assistance recipients sometime in the previous 3 years. Only 5 percent were recipients at the termination of rehabilitation services. Therefore, we have no factual explanation for the continuing increase in welfare expenditures. Further, a followup study of 193 rehabilitated clients revealed that of those rehabilitants who were recipients at the time of their acceptance for services, 63 percent were *not* receiving public assistance 2 to 4 years after their

TABLE 2.—*County Public Assistance Expenditures by Fiscal Year*

Fiscal year	County		
	Wood	Eau Claire	X of 6 controls
1963–64	1,238,788	1,887,879	1,145,331
1964–65	1,375,181	2,056,079	1,232,343
1965–66	1,375,215	2,056,004	1,286,751
1966–67	1,768,114	2,359,719	1,650,848
1967–68	2,850,574	3,155,523	2,673,077
1968–69	2,938,371	3,435,705	3,007,363
1969–70	3,607,634	3,643,274	3,272,700

Source: Department of Health and Social Services, Division of Public Assistance, Madison, Wis.

rehabilitation. The fact that the total DPW expenditures in Wood County were not reduced does not alter the positive results reported.

The economic impact of the project was only one of several social indicators used to assess its relative success. The results unquestionably demonstrated that the culturally handicapped can be successfully rehabilitated. In addition, they were found to (1) be as *feasible* for services, (2) be as *satisfied* with services, (3) make significantly *greater gains* as a result of services, and (4) *sustain* their rehabilitation gain long after the termination of services, as the medically-handicapped persons to whom vocational rehabilitation services have traditionally been offered. Also (aside from the public assistance records), an economic analysis of the project revealed, according to the benefit-cost formula used, that for every dollar invested in the rehabilitation of the culturally handicapped, $70 can be expected to be returned in increased, taxable, lifetime earnings (versus about $30 for medically handicapped).

The actual change in public assistance expenditures in Wood County is obscured and incalculable primarily because of the accounting change which separated medical assistance from the other categories, and also because of changes in eligibility criteria for receipt of assistance, increased benefits to individuals, reduced residency requirements, and a myriad of other factors. Hence, we cannot state unequivocally what the exact change was in the DPW public assistance expenditures during the tenure of the Wood County Project. Therefore, we would like all interested persons to be informed that the expansion of vocational rehabilitation to include the culturally handicapped did *not* reduce the Wood County DPW expenditures by 50 percent from fiscal year 1966 to 1967; instead, the total cost of public assistance continued to increase.

George N. Wright, Ph. D.
Director

Kenneth W. Reagles, Ph. D.
Research Director

Alfred J. Butler, Ph. D.
Research Professor

Six Rehab Giants

(Continued from page 28.)

cial liveliness about the work. It even includes a bit of humor now and then. One such bit concerns the late Dr. Wendell Johnson, who overcame his own stuttering problem and became a leading expert in that speech malady. He was fond of saying that American Indians did not stutter and that there was not even a word for stuttering in the tribal languages.

Two friends of Dr. Johnson's, knowing how he liked to make this reference, rightly guessed that he would do it again at a national meeting where he was to speak. They recruited a real, live Indian, fully garbed in ceremonial robes and headdress, and smuggled him into the back of the hall. At the right moment, they signalled him and he moved majestically up the aisle. He took the microphone from Dr. Johnson's uncertain hand and said in a loud voice: "Are you the D-D-Doctor Johnson who says In-In-Indians don't st-st-stutter?"

This is history told entertainingly. Those most interested in work for the handicapped will be happy that Russell Dean decided, as he puts it, to write this book "while the story is still fairly recent and many of the key figures can be consulted."

Watch Those Gestures

Learning about gestures can help a person communicate better. But it's a tough job. Besides the 2,500 to 4,000 languages and dialects in the world, there are 20,000 facial expressions and 700,000 gestures that can affect an interpretation. That's why it's not always what a person says that counts, but his actions as he says it. As many people are finding out, your eyes can hear too.

Northwestern Bell Magazine

REHABILITATION RECORD

Volume 13 (1972, Numbers 1–6, January Through December)

SUBJECT INDEX

	Month	Page
AGING		
Moving with	*July–Aug*	18
Using Color in a Geriatric Facility	*May–June*	9
ALABAMA, Rehab in Renal Failure	*Jan–Feb*	36
ANTHROPOLOGY, Work on Productive Participation.	*Jan–Feb*	10
ARCHITECTURAL BARRIERS		
Accessible Housing for Boston's Disabled.	*Nov–Dec*	24
Promise on the Prairie	*Nov–Dec*	1
Removal—Model Demonstration	*Nov–Dec*	18
Special Section on Transportation	*July–Aug*	1–18
ARKANSAS		
Keeping Them Down on the Farm.	*Sept–Oct*	14
Survival Camping with Problem Youth.	*May–June*	22
AUTOMATION, in the Health and Welfare Field.	*Mar–Apr*	14
AUTOMOBILE DRIVER, training	*July–Aug*	18
BLIND		
Audio Drama: A Mobile Theater by the.	*May–June*	11
Bowling: No Blind Alley	*May–June*	30
Home Teaching of the Adult	*Mar–Apr*	7
The State of Blindness; Its Counselors of State and its Citizens.	*Mar–Apr*	11
CALIFORNIA		
Barrier free Rapid Transit System	*July–Aug*	7
Mobile Service for the Homebound.	*May–June*	34
Therapeutic Housing	*Nov–Dec*	8
They Hit the Street Running	*Sept–Oct*	20
CAMPING		
Survival Camping with Problem Youth.	*May–June*	22
Tips for Retarded	*May–June*	15
CAPTIONING, Television for the Deaf	*Nov–Dec*	31
CASE HISTORIES, Attendant Pumps Gasoline and Understanding.	*Jan–Feb*	20
COMMUNITY RESOURCES, Utilization of	*Jan–Feb*	15
CONSUMERS		
Disabled People March for Civil Rights.	*Sept–Oct*	24
Involvement in Rehab	*July–Aug*	33
CONTEST, Wheelchairs with Pizazz	*Nov–Dec*	29
COUNSELING, Community Counseling Services for Deaf People.	*Sept–Oct*	9
DATA PROCESSING, Automation in the Health and Welfare Field.	*Mar–Apr*	14
DEAF		
Community Counseling Services for.	*Sept–Oct*	9
Diagnosis, Retardation, and Deafness.	*Mar–Apr*	24
Psychological Contributions of Dance to the Adjustment of the.	*May–June*	1
Television for	*Nov–Dec*	31
DELINQUENCY, Survival Camping with Problem Youth.	*May–June*	22
DIALYSIS		
Home	*Jan–Feb*	39
Rehab in Renal Failure	*Jan–Feb*	36
DIET		
Nutrition and Dietary Services in Social Rehab Programs.	*July–Aug*	28
Weight Control for Handicapped Adolescents.	*Sept–Oct*	27
DISADVANTAGED		
Home Ownership Brings Hope and Opportunity.	*Nov–Dec*	20
Industry: Training Ground for	*Sept–Oct*	33
Nutrition and Dietary Services in Social Rehab Programs.	*July–Aug*	28
DISTRICT OF COLUMBIA, Psychological Contributions of Dance to the Adjustment of the Deaf.	*May–June*	1
DRAMA, Audio Drama: A Mobile Theater by the Blind.	*May–June*	11
EMPLOYMENT		
Attendant Pumps Gasoline and Understanding.	*Jan–Feb*	20
Florida's Tin Can Caper	*July–Aug*	37
Homecraft: Source of Homebound.	*Sept–Oct*	1
Industry: Training Ground for Disadvantaged.	*Sept–Oct*	33
Keeping Them Down on the Farm.	*Sept–Oct*	14
Ohio's Project PREP	*Jan–Feb*	24
Rehab Acres—Minnesota's Farm Training Program.	*Jan–Feb*	32
EPILEPSY, Nonmedical Aspects	*Sept–Oct*	37
FLOOD SERVICES, West Virginia Agency Serves Flood Survivors.	*Sept–Oct*	16
FLORIDA, Tin Can Caper	*July–Aug*	37
GOODWILL INDUSTRIES, Volunteerism: Reawakening to an Age-Old Truth.	*Mar–Apr*	1

	Month	Page
GROUP HOMES, Dynamics of Residential Living.	Nov–Dec	14
HALFWAY HOUSES, Therapeutic Housing.	Nov–Dec	8
HOMEBOUND		
Homecraft: Source of Homebound Employment.	Sept–Oct	1
Mobile Service for the	May–June	34
Unbinding Homebound through Mobility.	July–Aug	11
HOMECRAFT, Source of Homebound Employment.	Sept–Oct	1
HOME TEACHING, of the Adult Blind	Mar–Apr	7
HOUSING, Special Section	Nov–Dec	1–26
INSURANCE, Rehabilitation Pilot Program.	Jan–Feb	27
INTERNATIONAL		
Music and Gymnastics for Toddlers.	May–June	37
Orange Picking in Israel	May–June	20
Sheltered Workshops in Sweden	Mar–Apr	35
IOWA, Weight Control for Handicapped Adolescents.	Sept–Oct	27
ISRAEL		
Is Salary Important?	Jan–Feb	3
Music and Gymnastics for Toddlers.	May–June	37
Orange Picking in	May–June	20
LEGISLATION		
Moving with the Aging	July–Aug	18
Transportation Overview	July–Aug	1
Wagner O'Day Amendments	Mar–Apr	30
MARCH, Disabled People March for Civil Rights.	Sept–Oct	24
MARY E. SWITZER, A Tribute	Jan–Feb	1
MASSACHUSETTS		
Accessible Housing for Boston's Disabled	Nov–Dec	24
Consumer Involvement in Rehab.	July–Aug	33
MENTAL HEALTH		
America's Major Diseases: Loneliness, Anxiety, Boredom	May–June	5
Diagnosis, Retardation, and Deafness.	Mar–Apr	24
Psychological Contributions of Dance to the Adjustment of the Deaf.	May–June	1
MENTAL RETARDATION		
Attendant Pumps Gasoline and Understanding.	Jan–Feb	20
Camping Tips for Retarded	May–June	14
Diagnosis, Retardation, and Deafness.	Mar–Apr	24
Dynamics of Residential Living	Nov–Dec	14
Florida's Tin Can Caper	July–Aug	37
Historical Overview of Recreation for the Retarded.	May–June	15
Orange Picking in Israel	May–June	20
Unbinding Homebound through Mobility.	July–Aug	11
MINNESOTA		
Promise on the Prairie	Nov–Dec	1
Rehab Acres—Minnesota's Farm Training Program.	Jan–Feb	32
MISSISSIPPI, Home Dialysis	Jan–Feb	39
MOBILITY, Unbinding Homebound through.	July–Aug	11
MUSIC, and Gymnastics for Toddlers	May–June	37
NEW JERSEY		
Home Ownership Brings Hope and opportunity	Nov–Dec	20
Insurance Rehab Pilot Program	Jan–Feb	27
NEW YORK		
Audio Drama: Mobile Theater by the Blind.	May–June	11
Long-Term Residential Facilities—The Unresolved Problem for Nonretarded, Severely Disabled Adults.	Nov–Dec	4
NUTRITION		
and Dietary Services in Social Rehab Programs.	July–Aug	28
Weight Control for Handicapped Adolescents.	Sept–Oct	27
OBITUARIES, Miss Mary Elizabeth Switzer:		
A Tribute	Jan–Feb	1
OHIO, Project Prep	Jan–Feb	24
OKLAHOMA, Architectural Barriers Removal—Model Demonstration and Information Center.	Nov–Dec	18
PARAPLEGIA, Major Competitive Sports for Wheelchair Athletes.	May–June	26
PENNSYLVANIA		
Black Students Prepare for Rehab Careers in Speech Therapy.	Mar–Apr	20
Community Counseling Services for Deaf People.	Sept–Oct	9
PRODUCTIVE PARTICIPATION, Work or	Jan–Feb	10
PUBLIC OFFENDER		
Ohio's Project Prep	Jan–Feb	24
They Hit the Street Running	Sept–Oct	20
RAPID TRANSIT, Barrier Free System	July–Aug	7
RECREATION	May–June	1–40
RESEARCH AND DEMONSTRATION, Crisis of Legitimacy.	Sept–Oct	6
RESEARCH UTILIZATION, of Community Resources.	Jan–Feb	15
SALARY, Is Salary Important?	Jan–Feb	3
SOCIAL ISOLATION, America's Major Diseases: Loneliness, Anxiety, Boredom	May–June	5
SPEECH THERAPY, Black Students Prepare for Careers in.	Mar–Apr	20
SPORTS		
Blind Bowling: No Blind Alley	May–June	30
Major Competitive Sports for Wheelchair Athletes.	May–June	26
SWEDEN, Sheltered Workshops in	Mar–Apr	35
THERAPEUTIC HOUSING	Nov–Dec	8
TRAINING		
Black Students Prepare for Rehab Careers in Speech Therapy.	Mar–Apr	20
Driver	July–Aug	18

	Month	Page
Home Teaching of the Adult Blind.	*Mar–Apr*	7
Industry: Training Ground for Disadvantaged.	*Sept–Oct*	33
Music and Gymnastics for Toddlers.	*May–June*	37
Rehab Acres—Minnesota's Farm Program.	*Jan–Feb*	32
TRANSPORTATION		
Mobile Service for the Homebound.	*May–June*	34
Special Section	*July–Aug*	1–18
TRAVEL, Another Aspect of Rehab	*May–June*	39
TV, for the Deaf	*Nov–Dec*	31
VIRGINIA, Recreation: Role in a Rehab Center.	*May–June*	18
VOCATIONAL GUIDANCE AND REHAB SERVICE, Nutrition and Dietary Services in Social Rehab Programs.	*July–Aug*	28
VOLUNTEERS, Volunteerism: Reawakening to an Age-Old Truth.	*Mar–Apr*	1
WAGNER O'DAY ACT AMENDMENTS	*Mar–Apr*	30
WEST VIRGINIA, Agency Serves Flood Survivors.	*Sept–Oct*	16
WHEELCHAIRS		
Transportation Overview	*July–Aug*	1
With Pizazz	*Nov–Dec*	29
WISCONSIN		
Handicabs	*July–Aug*	15
Homecraft: Source of Homebound Employment.	*Sept–Oct*	1
WORK, SPECIAL SECTION	*Jan–Feb*	3–19
WORK ETHIC, VR and the	*Jan–Feb*	7
WORKSHOP		
Rehab Acres—Minnesota's Farm Training Program.	*Jan–Feb*	32
Sheltered Workshops in Sweden	*Mar–Apr*	35
Wagner O'Day Amendments	*Mar–Apr*	30
WRITING, Television for the Deaf	*Nov–Dec*	31
YOUTH		
Survival Camping with Problem	*May–June*	22
Weight Control for Handicapped Adolescents.	*Sept–Oct*	27

AUTHOR INDEX

ALBERT, Bernard W	*May–June*	39
ALLWEIN, Herman	*Mar–Apr*	7
BEAN, William	*July–Aug*	1
BLEDSOE, Warren	*Mar–Apr*	11
BLISS, Susan D	*Nov–Dec*	1
BROWN, Spencer F	*Sept–Oct*	27
BRUBACHER, Rodger L	*Jan–Feb*	24
BRUBECK, Tom	*Sept–Oct*	20
CHAPPLE, Eliot D	*Jan–Feb*	10
COLLINGWOOD, Thomas R	*May–June*	22
CRAIG, William N	*Sept–Oct*	9
CRASE, Cliff	*May–June*	26
DOLNICK, Michael M	*Mar–Apr*	30
DUNN, John	*July–Aug*	15
ERDLE, Nancy F	*Sept–Oct*	27
FALKENSTEIN, Harriet	*July–Aug*	28
FENTON, Joseph	*Nov–Dec*	4
FREEBAIRN, Thomas	*Nov–Dec*	31
FREEMAN, B. L	*May–June*	15
GARCELON, Ann H	*Sept–Oct*	16
GRUNEWALD, Karl	*Nov–Dec*	14
HOOKER, Susan	*Nov–Dec*	31
IORIO, Samuel V	*Jan–Feb*	27
KARAN, Orville	*Sept–Oct*	37
KERR, L. D	*Sept–Oct*	14
KILCULLEN, Edward	*Mar–Apr*	24
KIMBERLY, John R	*Mar–Apr*	35
KOHLER, Anne T	*Jan–Feb*	15
LANCASTER, Georgene	*July–Aug*	28
LYNCH, Wallace	*May–June*	18
MACAROV, David	*Jan–Feb*	3
MARK, Frank R	*May–June*	5
MATHIAS, James	*July–Aug*	18
MILLER, Oral O	*May–June*	30
MORGAN, Jean M	*Jan–Feb*	36
MULVIHILL, John F. Jr	*Nov–Dec*	20
MUNDY, Jean	*May–June*	15
NOBLE, John H	*Sept–Oct*	6
	Mar–Apr	14
POMEROY, Janet	*May–June*	34
POSNER, Bernard	*Jan–Feb*	20
REECE, Clyde L	*July–Aug*	37
REMMES, Harold S	*Nov–Dec*	24
	July–Aug	33
RICHMOND, Charles	*Nov–Dec*	8
RIGDON, Dorothy	*Jan–Feb*	32
ROUPE, Diane	*Mar–Apr*	1
RUSK, Howard A	*Jan–Feb*	1
SALOMON, E. J	*May–June*	37
SCHEIN, Jerome	*Nov–Dec*	31
SEIFRIED, Julianne	*Sept–Oct*	9
SHROYER, Edgar	*Sept–Oct*	9
SIEGENTHALER, Bruce M	*Mar–Apr*	20
SUND, Bertram	*Nov–Dec*	31
SWAIN, Ryland	*July–Aug*	18
SWERDLOW, David	*May–June*	11
THOBEN, Patricia J	*Sept–Oct*	24
TILLMAN, Bruce J	*Nov–Dec*	18
TOWNE, Adrian	*Sept–Oct*	1
	Jan–Feb	7
TRELA, James	*July–Aug*	28
TRIANDIS, Harry C	*Sept–Oct*	33
USDANE, William M	*Mar–Apr*	30
VERNON, McCay	*Mar–Apr*	24
VOLPE, John A	*July–Aug*	Cover II
WEINGOLD, Joseph	*July–Aug*	11
WILLSON, Harold L	*July–Aug*	7
WISHER, Peter R	*May–June*	1

U.S. GOVERNMENT PRINTING OFFICE: 1972

REHABILITATION RECORD

The weakest ink is better than the strongest memory

contents

NOVEMBER–DECEMBER 1972
VOLUME 13, NUMBER 6

Page

Housing

Congressional Hearings on Barriers ..... Cover II

Promise On The Prairie 1
Susan D. Bliss

Long Term Residential Facilities 4
Joseph Fenton

Therapeutic Housing 8
Charles Richmond

Dynamics of Residential Living 14
Karl Grunewald

Architectural Barriers Removal 18
Bruce J. Tillman

Home Ownership Brings Hope and Opportunity 20
John F. Mulvihill, Jr.

Accessible Housing For Boston's Disabled 24
Harold S. Remmes

Review: "New Life For Millions" 28
Dorothy Rigdon

Wheelchairs With Pizazz 29

Television For The Deaf 31
Jerome Schein, Thomas Freebairn, Bertram Sund, Susan Hooker

1972 Index 38

Features

New publications, page 27 . . . Commentary, page 35.

Published by

Rehabilitation Services Administration

Edward Newman
Commissioner

Ron Bourgea, Editor
Room 3213, HEW South Building
Washington, D.C. 20201

Wilma Chinn
Editorial Assistant

Use of funds for printing the Rehabilitation Record was approved by the Director of the Bureau of the Budget, January 5, 1966. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price 55 cents (single copy). Subscription price: $3 per year, 75 cents additional for foreign mailing.

Opinions expressed in this publication are those of their authors. They do not necessarily reflect the views of the Department and Agency.

MAIL ORDER FORM

To: Government Printing Office
Washington, D.C. 20402

FOR USE OF SUPT. DOCS.

Enclosed is $..... (check or money order) for a subscription to Rehabilitation Record (6 issues annually) for one ☐, two ☐, or three ☐ years. Annual subscription is $3, plus 75 cents for foreign mailing.

Name .....

Street address .....

City, State, and ZIP Code .....

UNITED STATES
GOVERNMENT PRINTING OFFICE
DIVISION OF PUBLIC DOCUMENTS
WASHINGTON, D.C. 20402

OFFICIAL BUSINESS

REHABILITATION RECORD

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

Rehabilitation Services Administration

Washington, D.C. 20201